



**Customer Service and Courier Pickup**  
916-446-0424; Toll-free 800-464-0424  
FAX 916-446-9330 www.dpmginc.com  
3301 C Street, #200E, Sacramento, CA 95816

Form completed by: \_\_\_\_\_

*Please fill out this form completely and place completed specimen label sticker on each container*

Additional Copies of Report To (Name and Address): \_\_\_\_\_

Patient Name: Last, First			Date Specimen Taken	
Patient Address		City	Zip Code	Telephone Number
Date of Birth	Age	Sex	MRN	
INSURANCE <input type="checkbox"/> Copy of insurance card(s) attached <input type="checkbox"/> Cash pay patient				

**( Signed ABN Required for Medicare Patients. Please see reverse side for ABN )**

<p><b>CERVICAL CANCER SCREENING</b></p> <p><input type="checkbox"/> PAP Source: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cervical <input type="checkbox"/> Endocervical</p> <p><input type="checkbox"/> HPV regardless of Pap result or age  <input type="checkbox"/> HPV if Pap is ASCUS/ASC-H  <input type="checkbox"/> HPV if Pap is Abnormal  <input type="checkbox"/> HPV only (no Pap)</p> <p><input type="checkbox"/> Reflex HPV Genotyping 16, 18/45</p> <p><b>FOLLOW ACOG AGE RELATED TESTING GUIDELINES</b></p> <p><input type="checkbox"/> Age 21-24 Pap and CT/NG, Reflex HPV if Pap ASCUS  Age 25-29 Pap with reflex HPV if Pap ASCUS  Age 30-65 Pap with HPV (co-testing)  Pap neg &amp; HPV pos, reflex HPV 16, 18/45</p>	<p><b>GYN HISTORY</b></p> <p>LMP Date _____ <input type="checkbox"/> Contraceptive  <input type="checkbox"/> Post Partum <input type="checkbox"/> Pregnant  <input type="checkbox"/> Post/Peri Menopausal <input type="checkbox"/> IUD  <input type="checkbox"/> Postmenopausal Bleeding <input type="checkbox"/> Other _____</p> <p><b>Clinical Diagnosis:</b> _____</p> <p><b>Diagnostic Code(s):</b> _____</p> <p>Screen for Malign Neo Z12.4 Vaginitis N76.0  Gyn exam w/o abnormality Z01.419 HPV Screening Z11.51  Non-Inflammatory Vag Disorders N89.8  Screening for Infections w/ Sexual Mode of Transmission Z11.3</p>
---	--

<p><b>MOLECULAR TESTING</b></p> <p><b>Pap Vial, Aptima Swab or Urine Transport Tube</b></p> <p><input type="checkbox"/> Chlamydia  <input type="checkbox"/> Gonorrhea  <input type="checkbox"/> Trichomonas</p>	<p><b>Aptima Swab Only</b></p> <p><input type="checkbox"/> Vaginitis: CV (Candida species &amp; C. Glabrata)  BV (Gardnerella &amp; Lactobacillus) &amp; Trich  <input type="checkbox"/> HSV 1 &amp; 2</p>	<p><b>BD Affirm Swab (72 hr viability)</b></p> <p><input type="checkbox"/> Vaginitis: Candida, Gardnerella, Trich</p>
---	--	---

**URINE CYTOLOGY/FISH (UroVysion) - Please check one**

Cytology  Cytology/FISH  Cytology/reflex FISH (atypical results)  FISH only

**Diagnostic Code(s):** \_\_\_\_\_

*Patient full name required - Place completed specimen label sticker on each container*

Name _____ Date _____ (Last/First) Specimen C00625621-1	Name _____ Date _____ (Last/First) Specimen C00625621-2
---	---

C00625621-3

A. Notifier:

B. Patient Name:

C. Identification Number:

## Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for D. \_\_\_\_\_ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
<input type="checkbox"/> 88142 Thin Prep Pap Smear	Medicare does not pay for this test as often (denied as too frequent)	\$55.00
<input type="checkbox"/> 88175 Thin Prep Pap Smear, automated screening		\$64.47
<input type="checkbox"/> 88164 Conventional Pap Smear		\$31.00
<input type="checkbox"/> 88141 Path Screening / Atypical		\$54.85

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the D. \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

### H. Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

<b>I. Signature:</b>	<b>J. Date:</b>
----------------------	-----------------

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

LINER