*D*iagnostic
*P*athology
*M*edical
*G*roup, Inc.

Additional Testing
Authorization Form for Liquid Based Cytology Specimens

Submit this form to order additional testing out of a ThinPrep or SurePath vial.
Please note the following criteria:

ThinPrep: Additional testing may be ordered up to **21 days** from the collection date.
SurePath: Additional testing may be ordered up to **14 days** from the collection date.

I authorize Diagnostic Pathology Medical Group, Inc. (DPMG) to perform the following test(s) on my patient:

☐ Chlamydia ☐ Gonorrhea ☐ Trichomonas

☐ HPV ☐ HPV Genotyping 16/18/45

Patient's Name: _____

Patient's Insurance: _____

Date of Birth: _____ Pap Report Number: _____

Physician's Name: _____ Phone Number: _____

It is the responsibility of the ordering physician to obtain prior authorization for this service if required as part of the patient's healthcare coverage. By my signature below, I acknowledge that DPMG is not financially responsible for payment of the additional tests ordered.

Physician's Signature: _____ Date: _____

IF CONFIRMATION OF ORDER IS REQUIRED PLEASE INCLUDE YOUR FAX NUMBER FOR A FAX BACK: _____

Please fax this form to (916) 446-9330

Order Received: Date:_____Time:_____Initials:_____

If you have any questions please feel free to contact Customer Service at (916) 446-0424
3301 C Street, #200-E, Sacramento, California 95816