AVERO® DIAGNOSTICS

GY00001

GYN PATHOLOGY REQUISITION

For Lab Use Only
DO NOT place anything or write in this space.

PATIENT INFORMATION

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH (MM/DD/YYYY) | PATIENT MRN

TELEPHONE NUMBER

SEX
☐ Female ☐ Male ☐ Other/Unknown

STREET NUMBER | STREET NAME | APT NUMBER

CITY | STATE | ZIP

ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I may be responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031 (b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim.

PATIENT SIGNATURE | DATE (MM/DD/YY)
X

SPECIMEN INFORMATION – REQUIRED

Collected on: | Time: ☐ AM ☐ PM

CLINICIAN INFORMATION

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.

REQUIRED ORDERING CLINICIAN SIGNATURE
X

DATE (MM/DD/YY)

BILLING INFO

☐ **BILL INSURANCE** Attach legible front and back copy of insurance cards.

INSURANCE COMPANY

IPA NAME

MEMBER ID

☐ **BILL PATIENT** (Cash pay, no insurance)
☐ **CLIENT BILL**

DIAGNOSTIC INFORMATION (ICD-10) (Check all that apply)

☐ **MEDICARE SCREENING - See Medicare Section & Sign Advance Beneficiary Notice of Noncoverage (ABN)**

- ☐ C53.9 Malignant neoplasm of cervix uteri, unsp.
- ☐ N72 Inflammatory disease of cervix uteri
- ☐ N76.0 Acute vaginitis
- ☐ N76.1 Subacute and chronic vaginitis
- ☐ N76.2 Acute vulvitis
- ☐ N76.3 Subacute and chronic vulvitis
- ☐ N87.9 Dysplasia of cervix uteri, unsp
- ☐ N89.7 Hematocolpos
- ☐ N92.5 Other sp. irr. menstruation
- ☐ N93.8 Other sp. abnl. uterine bleeding
- ☐ N95.0 Postmenopausal bleeding
- ☐ N95.2 Postmenopausal atrophic vag.
- ☐ R87.615 Unsat. ctyo smear cervix
- ☐ R87.619 Unsp ab. cyto. from cervix urteri
- ☐ Z34.01 Enctr suprvn norm 1st preg, 1st
- ☐ Z34.02 Enctr suprvn norm 1st preg, 2nd
- ☐ Z34.03 Enctr suprvn norm 1st preg, 3rd
- ☐ Other: _____
- ☐ Z34.81 Enctr suprvn norm preg, 1st tri.
- ☐ Z34.82 Enctr suprvn norm preg, 2nd tri.
- ☐ Z34.83 Enctr suprvn norm preg, 3rd tri.
- ☐ Z01.411 Enctr Gyn (gnrl) w/abnl. finding
- ☐ Z01.419 Enctr Gyn (gnrl) w/o abnl finding
- ☐ Z11.51 Enctr for screen HPV
- ☐ Z11.3 Enctr screen infect w/sex transmiss
- ☐ Z12.4 Enctr screen malig. neo. cervix
- ☐ Other: _____
- ☐ Z12.72 Enctr screen malig. neo. vagina
- ☐ Z34.00 Enctr suprvsn norm 1st preg unsp
- ☐ Z34.80 Enctr suprvsn norm preg usp
- ☐ Z77.21 Cont. w Exp. to pot. hazard fl.
- ☐ Z91.89 Other personal risk factors
- ☐ Z13.71 Nonprocreative screening for genetic disease carrier status
- ☐ Z31.430 Female for testing for genetic disease carrier status for procreative mgmt
- ☐ Other: _____

CLINICAL INFORMATION (Check all that apply)

ABNORMAL PAP: (Date: _____)
☐ ASCUS ☐ LGSIL ☐ ASC-H ☐ HGSIL ☐ AGC

☐ Abnl. Appearing Cervix ☐ History of Cancer ☐ Hormone Therapy ☐ IUD ☐ Postpartum ☐ Supracervical Hysterectomy
☐ Birth Control / OCP Method? _____ ☐ History of Radiation ☐ Hysterectomy ☐ Post Menopausal ☐ Pregnant ☐ Other: _____

GYN CYTOLOGY & MOLECULAR

SPECIMEN SOURCE:
☐ Cervix/Endocervix ☐ Vagina ☐ Oral ☐ Anal

LMP or Menopause Date:

☐ Pap Test (follow provider-driven rules on file)
○ Disregard provider-driven rules

☐ Pap Test: Reflex to High-risk HPV Onclarity if Pap:
○ ASC-US
○ ASC-US or above

☐ Pap & High-risk HPV Onclarity*

☐ Pap, High-risk HPV Onclarity*, *Chlamydia & N. gonorrhoeae* (NAAT)

☐ Pap, High-risk HPV Onclarity*, *Chlamydia, N. gonorrhoeae & Trichomonas vaginalis* (NAAT)

*Test specifically identifies types 16, 18, 31, 45, 51, and 52 while reporting the other HR HPV types in groups (33/58, 35/39/68, and 56/59/66).

☐ Dtex Cervical FISH Test
○ Reflex if Pap ASC-US/High-risk HPV Positive
○ Reflex if Pap LSIL: _____

☐ HPV Primary Screen

MEDICARE - Patients with screening Paps must sign ABN on the back page. HPV every 5 years.

☐ Medicare Screening Pap, Low-risk, Cervical - 2 yrs. Dx: Z12.4
☐ Medicare Screening Pap, Low-risk, Vagina - 2 yrs. Dx: Z12.72
☐ Medicare Screening Pap, Routine Exam - 2 yrs. Dx: Z01.419
☐ Medicare Screening Pap, Routine Exam, w/abnormal findings - 2 yrs. Dx: Z01.411
☐ Medicare Screening Pap, High-risk, Medical Hx - 1 yr. Dx: Z91.89

OTHER CYTOLOGY

SPECIMEN SOURCE: ☐ Right Breast ☐ Left Breast ☐ Anal

☐ Anal Pap Test
☐ Anal Pap Test w/ HR HPV
☐ Breast Nipple Aspirate (Direct Smear)

MOLECULAR TESTS AND PANELS

STD TESTING
- ☐ Leukorrhea Panel (CT/NG/TV)
- ☐ Leukorrhea Extended Panel
- ☐ *Chlamydia trachomatis* (NAAT)
- ☐ *Neisseria gonorrhoeae* (NAAT)
- ☐ *Trichomonas vaginalis* (NAAT)
- ☐ Herpes Simplex Virus 1 & 2 (NAAT)
- ☐ *Treponema pallidum* (Syphilis)

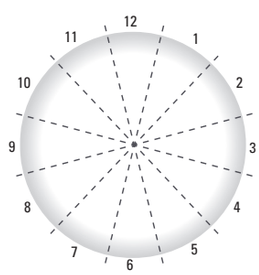
SYMPTOMATIC TESTING
(see reverse for panel organisms)
- ☐ Aerobic Vaginitis Panel
- ☐ Bacterial Vaginitis Panel
- ☐ Candidiasis Panel
- ☐ Cervicitis/Vaginitis Panel
- ☐ Genital Ulcer Panel
- ☐ Mycoplasma Panel
- ☐ PID/Infertility Panel
- ☐ Standard Panel
- ☐ Ureaplasma
- ☐ UTI Complete™ Panel by RT-PCR
- ☐ Vaginosis/Vaginitis Panel
- ☐ Vaginosis/Vaginitis Extended Panel

PERINATAL TESTING
- ☐ Group B Streptococcus by RT-PCR
- ☐ Group B Streptococcus by RT-PCR w/ Reflex to susceptibility

GYNECOLOGIC HISTOLOGY

- ☐ **A. Cervical Biopsy**
- ☐ **B. Endocervical Curetting - ECC**
- ☐ **C. LEEP**
- ☐ **D. Cervical Cone**
- ☐ **E. Endometrial Biopsy - EMB**
- ☐ **F. Vaginal Biopsy**
- ☐ **G. Vulvar Biopsy**
  - ☐ **labia majora** ☐ **labia minora**
  - ☐ **rash** ☐ **neoplasm**
  - **Relevant clinical description or history:**
- ☐ **H. Perineum Biopsy**
- ☐ **I. Other** _____
- ☐ **J. Other** _____

Please Note the Biopsy Site(s)



Cervical Diagram with Patient in Lithotomy Position

AV-23023-01 REV 032023

GY00001 DOB: _____ PATIENT NAME _____

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AVERO® DIAGNOSTICS

Bellingham Laboratory
3560 Meridian Street, Suite 101
Bellingham, WA 98225
360.527.4580

Dallas Laboratory
6221 Riverside Drive, Suite 119
Irving, TX 75039
877.232.9924

www.averodx.com

A. Notifier: _____

B. Patient Name: _____ **C. Identification Number:** _____

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (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

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.

I. Signature	J. Date

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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.

Form CMS-R-131 (Exp. 01/31/2026) *Form Approved OMB No. 0938-0566*

SYMPTOMATIC TESTING PANEL ORGANISMS

Leukorrhea Panel	*Chlamydia trachomatis, Neisseria gonorrhoeae, Trichomonas vaginalis*
Leukorrhea Extended Panel	*Chlamydia trachomatis, Neisseria gonorrhoeae, Trichomonas vaginalis, Mycoplasma genitalium*
Aerobic Vaginitis Panel	*Staphylococcus aureus, Streptococcus agalactiae (group B), Enterococcus faecalis, Escherichia coli*
Bacterial Vaginosis Panel	*Gardnerella vaginalis, Atopobium vaginae, Megasphaera spp. Type I, BVAB2, Mobiluncus curtisii, Mobiluncus mulieris, Lactobacillus crispatus, Lactobacillus gasseri, Lactobacillus jensenii*
Candidiasis Panel	*Candida albicans, Candida tropicalis, Candida parapsilosis, Candida glabrata, Candida krusei*
Cervicitis/Vaginitis Panel	Leukorrhea Panel, Bacterial Vaginitis Panel, Candidiasis Panel, Mycoplasma Panel, Ureaplasma
Genital Ulcer Panel	Herpes Simplex Virus 1 & 2, *Haemophilus ducreyi (chancroid), Treponema pallidum (syphilis)*
Mycoplasma Panel	*Mycoplasma hominis, Mycoplasma genitalium*
PID/Infertility Panel	Leukorrhea Panel, Bacterial Vaginitis Panel, Mycoplasma Panel, Ureaplasma
Standard Panel	*Lactobacillus crispatus, Lactobacillus gasseri, Lactobacillus jensenii, Gardnerella vaginalis, Atopobium vaginae, Megasphaera spp. Type I, BVAB2, Candida albicans, Candida glabrata*
Ureaplasma	*Ureaplasma urealyticum*
UTI Complete™ Panel	*Acinetobacter baumannii, Actinobaculum schaalii, Aerococcus urinae, Alloscardovia Omnicolens, Candida albicans, Candida auris, Candida glabrata, Candida parapsilosis, Citrobacter freundii, Citrobacter koseri, Coagulase Negative Staph, Corynebacterium riegelii, Enterobacter aerogenes, Enterobacter cloacae, Enterococcus faecalis, Enterococcus faecium, Escherichia coli, Klebsiella oxytoca, Klebsiella pneumoniae, Morganella morganii, Mycoplasma hominis, Pantoea agglomerans, Proteus mirabilis, Proteus vulgaris, Providencia stuarti, Pseudomonas aeruginosa, Serratia marcescens, Staphylococcus aureus, Streptococcus agalactiae, Ureaplasma urealyticum, Viridans Group Strep*
Vaginosis/Vaginitis Panel	*Trichomonas vaginalis* (NAAT), Bacterial Vaginitis Panel, Candidiasis Panel
Vaginosis/Vaginitis Extended Panel	Leukorrhea Panel, Bacterial Vaginitis Panel, Candidiasis Panel