



# GYN PATHOLOGY REQUISITION – SUREPATH™

## 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

ORDERING CLINICIAN SIGNATURE \_\_\_\_\_ DATE (MM/DD/YY) \_\_\_\_\_

**REQUIRED** X

**BILLING INFO**

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

INSURANCE COMPANY \_\_\_\_\_

IPA NAME \_\_\_\_\_

MEMBER ID \_\_\_\_\_

BILL PATIENT Patient will be contacted to provide payment method.

CLIENT BILL

**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 test(s) requested herein.

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

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

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

## CLINICAL INFORMATION (Check all that apply)

**ABNORMAL PAP:** (Date: \_\_\_\_\_)  Abnl. Appearing Cervix  History of Cancer  Hormone Therapy  IUD  Postpartum  Supracervical Hysterectomy

ASCUS  LGSIL  ASC-H  HGSIL  AGC  Birth Control / OCP  History of Radiation  Hysterectomy  Post Menopausal  Pregnant  Other: \_\_\_\_\_

Method? \_\_\_\_\_

## GYN CYTOLOGY & MOLECULAR (SUREPATH™ ONLY)

**SPECIMEN SOURCE:**  Cervix/Endocervix  Vagina

**LMP or Menopause Date:** \_\_\_\_\_

Pap Test

Pap Test: Reflex to High-risk HPV\* if Pap:  
 ASC-US  ASC-US or above

High-risk HPV\*  
*\*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: \_\_\_\_\_  
 Reflex if Other: \_\_\_\_\_

## GYNECOLOGIC HISTOLOGY (DIAGRAM)

A. Endocervical Curetting - ECC

B. Endometrial Biopsy - EMB

C. Cervical Biopsy

D. Cervical Cone

E. Labial Biopsy

F. LEEP

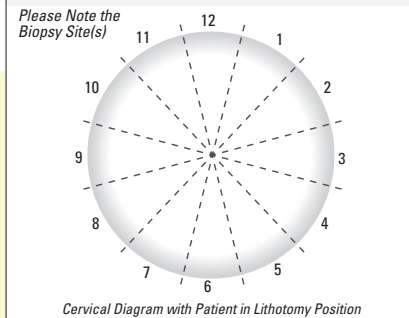
G. Perineum Biopsy

H. Vaginal Biopsy

I. Vulvar Biopsy

J. Other \_\_\_\_\_

K. Other \_\_\_\_\_



## MOLECULAR TESTS & PANELS

**For asymptomatic patients, Medicare requires a letter of Medical Necessity.**

**STD TESTING**

Leukorrhea Panel (CT/NG/TV) X

Chlamydia trachomatis (NAAT) X

Neisseria gonorrhoeae (NAAT) X

Trichomonas vaginalis (NAAT) X

Herpes Simplex Virus 1 & 2 (NAAT) X

**PERINATAL TESTING**

Group B Streptococcus by RT-PCR X

Group B Streptococcus by RT-PCR w/ Reflex to susceptibility X

**SYMPTOMATIC TESTING (see reverse for panel organisms)**

Aerobic Vaginitis Panel X

BD Affirm™ Vaginosis Panel X

Bacterial Vaginitis Panel X

Candidiasis Panel X

Cervicitis/Vaginitis Panel X

Mycoplasma Panel X

PID/Infertility Panel X

Standard Panel X

Ureaplasma Panel X

Vaginosis/Vaginitis Panel X

Vaginosis/Vaginitis Extended Panel X

**Collection Requirement Key:**  
 See Specimen Guide for additional specimen types

Aptima™ Multitest Swab Stability: 4 weeks ambient

Copan eSwab™ Stability: 2 days ambient

## 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

Halo™ Breast Pap Test  Anal Pap Test

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

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

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**SYMPTOMATIC TESTING PANEL ORGANISMS**

Leukorrhea Panel	<i>Chlamydia trachomatis, Neisseria gonorrhoeae, Trichomonas vaginalis</i>
Aerobic Vaginitis Panel	<i>Staphylococcus aureus, Streptococcus agalactiae (group B), Enterococcus faecalis, Escherichia coli</i>
BD Affirm™ Vaginosis Panel	Candida, Gardnerella, Trichomonas
Bacterial Vaginosis Panel	<i>Gardnerella vaginalis, Atopobium vaginae, Megasphaera spp. Type I, BVAB2, Mobiluncus curtisii, Mobiluncus mulieris, Lactobacillus crispatus, Lactobacillus gasseri, Lactobacillus jensenii</i>
Candidiasis Panel	<i>Candida albicans, Candida tropicalis, Candida parapsilosis, Candida glabrata, Candida krusei</i>
Cervicitis/Vaginitis Panel	Leukorrhea Panel, Bacterial Vaginitis Panel, Candidiasis Panel, Mycoplasma Panel, Ureaplasma Panel
Mycoplasma Panel	<i>Mycoplasma hominis, Mycoplasma genitalium</i>
PID/Infertility Panel	Leukorrhea Panel, Bacterial Vaginitis Panel, Mycoplasma Panel, Ureaplasma Panel
Standard Panel	<i>Lactobacillus crispatus, Lactobacillus gasseri, Lactobacillus jensenii, Gardnerella vaginalis, Atopobium vaginae, Megasphaera spp. Type I, BVAB2, Candida albicans, Candida glabrata</i>
Ureaplasma Panel	<i>Ureaplasma parvum, Ureaplasma urealyticum</i> (detects but does not differentiate)
Vaginosis/Vaginitis Panel	<i>Trichomonas vaginalis</i> (NAAT), Bacterial Vaginitis Panel, Candidiasis Panel
Vaginosis/Vaginitis Extended Panel	Leukorrhea Panel, Bacterial Vaginitis Panel, Candidiasis Panel