BPMG Bakersfield Pathology Medical Group

Gyn Cytology Request Form

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Collection Date: _____ **Specimen Number:** _____

Submitting Physician: _____

Patient Informations: Name (Last, First, Middle): _____ DOB _____/_____/_____ Sex: ☐ M ☐ F

SSN: _____ – _____ – _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Med Rec# / Patient #: _____

Billing Information: Face Sheet & Copy of Insurance Card Must be Attached

Bill: ☐ Insurance ☐ Medical ☐ Cash Amount Enclosed $

☐ Bill Patient's VISA/MC: Exp. Date: _____ Card #: _____ Authorized Signature: _____

☐ **Bill Medicare: CMS requires the physician to provide ICD-9 code(s) on Medicare specimen(s). ABN for PAP smears must be signed by patient at time of service. Signature required on back of form.**

Authorization #: _____ Medicare #: _____

UPN#: _____ Healthplan _____ Ins. Phone: _____

Address: _____

Policy/Cert #: _____ Group/Plan #: _____ Medical Group: _____ Employer's Name: _____

Name of Insured: _____ Relationship to Insured: _____ Secondary Insurance: ☐ Yes ☐ No (If YES, please attach a separate sheet)

Advance Beneficiary Notice (ABN)

All third part payers including Medicaare and MediCal will only pay for laboratory services that they consider to be "medically necessary." When Medicare or MediCal decide that a laboratory service is not "medically necessary," they will deny payment. The patient understands and acknowledges his/her responsibility for payment for laboratory services not covered by Medicare or MediCal.

Patient Signature: _____

Specimen Type: ☐ **Cervix** ☐ **Vaginal** ☐ **Liquid Based (Thin-Layer Surepath) or** ☐ **Conventional**

Additional Request (For Liquid Based Specimen):

☐ **HPV Reflex**: ☐ if ASCUS/AGUS ☐ if LSIL ☐ if HSIL ☐ Request Maturation Index (vaginal smear only)

☐ HPV ☐ Gonorrhea ☐ Chlamydia

Clinical History:

Date of Last PAP: _____/_____/_____ LMP: _____/_____/_____ ☐ Regular ☐ Irregular ☐ Pregnant ☐ Post-Partum ☐ Perimenopausal ☐ Postmenopausal

Prior Operation: _____ on _____/_____/_____ Prior Biopsy/Curettings on _____/_____/_____ Contraceptive: ☐ Oral ☐ IUD ☐ Other

Radiation Therapy _____ < 90 days Ago _____ 90+ Days Ago

Drug Therapy: ☐ Current ☐ Prior History

☐ Exogenous Hormones ☐ Cytoxic Agent ☐ Tamoxifen ☐ Other: _____ High Risk for C/V CA due to: _____

Present Complaint or Physical Findings:

☐ Routine (No current Complaint/Prior Problems)
☐ Previous Abnormal Pap
☐ Possible Condyloma
☐ Possible Herpes
☐ Abnormal Bleeding
☐ Cervical Lesion
☐ Pelvic Mass
☐ Infection: _____
☐ Other: _____

Prior report of abnormal diagnosis:

☐ ASCUS ☐ HSIL ☐ HPV ☐ High Risk
☐ LSIL ☐ Other ☐ Low Risk

GYN-Cytology Charges: ☐ 88141 Liquid Base QA ☐ 88142 GYN Liquid Base ☐ 88150 Conventional Pap ☐ 88142 Conventional QA ☐ 88365 HPV Global ☐ 88274

ICD-9/S Codes (Please Check, If Applicable):

☐ Nonspecific abnormal Papanicolaou smear of cervix - unspecified	795.00	☐ Dysplasia	622.1	☐ Routine	V76.2
☐ ASCUS favor benign	795.01	☐ Metrorrhagia	626.6	☐ Oral Contraceptives-Eval Prior to Method	S10.1
☐ ASCUS favor dysplasia	795.02	☐ Pregnancy State	V22.0/V22.2	☐ Oral Contraceptives-Maintain Adherence	S10.2
☐ Other nonspecific abnormal Papanicolaou smear of cervix	795.09	☐ Routine Postpartum Follow Up	V24.2	☐ Depo-Provera Injection-Eval prior to method	S20.1
☐ Atrophic Vaginitis	627.3	☐ Vaginitis	616.10	☐ Barriers and spermicide-Eval prior to method	S50.1
		☐ Menopause	627.2	☐ Barriers and spermicide-Maitain adherence	S50.2
		☐ Cervicitis	616.0	☐ Other:	

ICD-9-CM Diagnosis Code(s) for current Pap Smear (Requesting Physician's Rational for Ordering Test): _____