STANFORD UNIVERSITY MEDICAL CENTER

Surgical Pathology & Cytology Laboratories

Requisition #

Facility Name and Address:

Phone Number: (______) ____________________

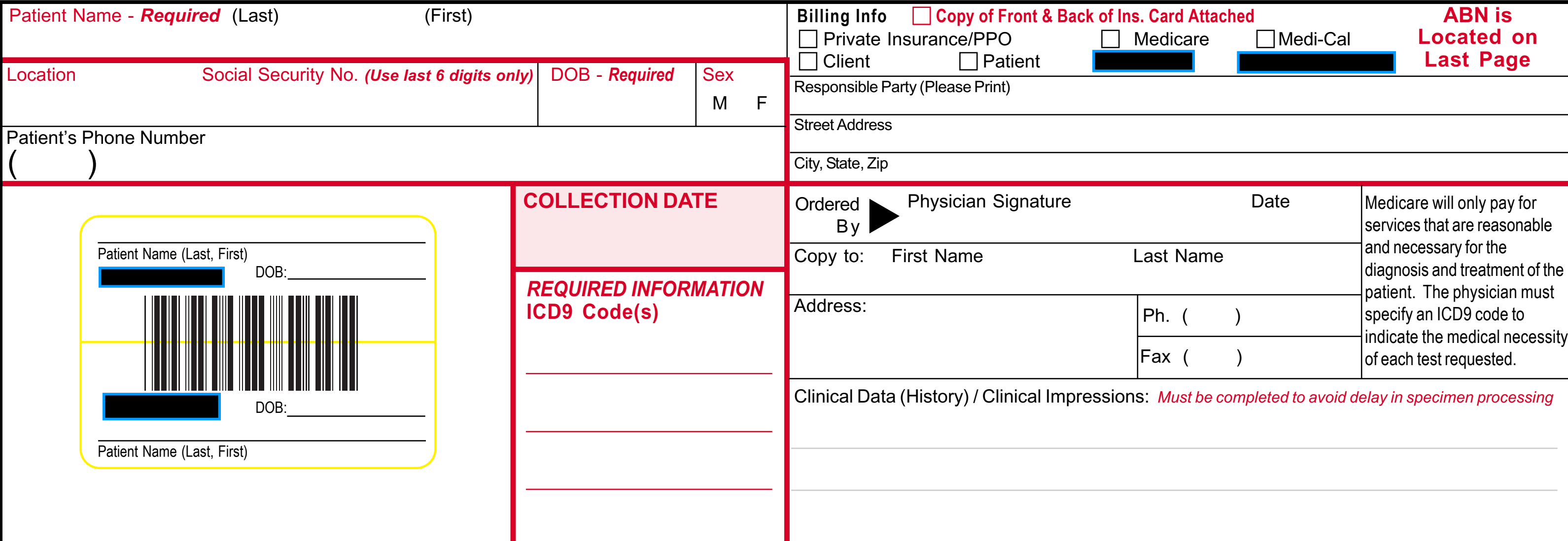
Fax Number:(______) ______________________

Ordering Physician Name: ____________________

NPI #: ____________________________

For Lab Use Only

PLACE ACCESSION LABEL HERE



Patient Name - ***Required*** (Last) (First)

Location | Social Security No. ***(Use last 6 digits only)*** | DOB - ***Required*** | Sex M F

Patient's Phone Number ( )

Billing Info ☐ Copy of Front & Back of Ins. Card Attached

☐ Private Insurance/PPO ☐ Medicare ☐ Medi-Cal

☐ Client ☐ Patient

ABN is Located on Last Page

Responsible Party (Please Print)

Street Address

City, State, Zip

Patient Name (Last, First)

DOB:

DOB:

Patient Name (Last, First)

COLLECTION DATE

REQUIRED INFORMATION
ICD9 Code(s)

Ordered By ▶ Physician Signature Date

Copy to: First Name Last Name

Address: Ph. ( ) Fax ( )

Medicare will only pay for services that are reasonable and necessary for the diagnosis and treatment of the patient. The physician must specify an ICD9 code to indicate the medical necessity of each test requested.

Clinical Data (History) / Clinical Impressions: *Must be completed to avoid delay in specimen processing*

GYN CYTOLOGY - PAP SMEAR SPECIMEN - *Please Label with Patient Name and Date of Birth*

SPECIMEN TYPE & TESTS REQUESTED:

		Test	Code
Thin Prep®	☐	Pap Only	CYPAPTP
	☐	Pap with GC/Chlamydia	CLGCT2
	☐	HR-HPV if ASC-US	HPVHR2
	☐	HR-HPV if ASC-US & Above	HPVHR2
	☐	HR-HPV with Pap	CYPAPTP, HPVHR2
Sure Path®	☐	Pap Only	CYPAPTL
	☐	Pap wtih GC/Chlamydia	CLGCT2
	☐	HR-HPV if ASC-US	HPVHR2
	☐	HR-HPV if ASC-US & Above	HPVHR2
	☐	HR-HPV with Pap	CYPAPTL, HPVHR2
Conventional	☐	Pap Only	CYPAP1

SPECIMEN SOURCE - (Required): ☐ Vaginal ☐ Vaginal / Cervical (☐ Anal Pap)

Last Menses (LMP Date): ____________________

☐ Postmenopausal ☐ Pregnant ☐ Postpartum

☐ Previous Abnormal Pap - Date(s): ____________________

☐ Current Hormone Therapy, Specify: ____________________

Radiation? ☐ No ☐ Yes, When: ____________________

Chemotherapy? ☐ No ☐ Yes, When: ____________________

MEDICARE/ HEALTHCARE PATIENTS: ***Please Check One Box for All Medicare/Healthcare Patients***

☐ High Risk Screening ☐ Low Risk Screening ☐ Diagnostic Pap Smear

NON-GYN CYTOLOGY SPECIMENS - *Please Label with Patient Name and Date of Birth*

LUNG

☐ Sputum

☐ Bronchial Brush, Site: __________

☐ Bronchial Wash, Site: __________

☐ Bronchoalveolar Lavage (BAL)

☐ (GMS) Grocott Methenamine Silver Stain for Fungus and PCP

☐ Other Stains: ________________

BODY CAVITIES

☐ Pleural Fluid __________

☐ Pericardial Fluid

☐ Abdominal Fluid

☐ Pelvic Wash

CENTRAL NERVOUS SYSTEM

☐ (CSF) Cerebrospinal Fluid

☐ Shunt

URINE SPECIMENS

Source: ☐ Voided ☐ Catheterized ☐ Bladder Wash

☐ Cytology Only

☐ Cytology with Reflex to Bladder Cancer Testing by UroVysion FISH™

☐ Bladder Cancer Testing by UroVysion FISH™

MISCELLANEOUS SITE

☐ Bile Duct Brush

☐ Other: ________________

FINE NEEDLE ASPIRATION

☐ Specify Site: ______________

☐ Air-Dried, # of Smears: __________

☐ Fixed, # of Smears: __________

☐ Other: ________________

SURGICAL SPECIMENS

List each specimen separately and accurately

1.

2.

3.

COMMENTS:

FOR LAB USE ONLY Cytotechnologist:

Notes:

Patient's First Name: ____________________

Last Name: ____________________

Patient's MRN: ____________________

Or Affix Label Here

STANFORD UNIVERSITY MEDICAL CENTER

CLINICAL LABORATORIES
3375 Hillview Avenue
Palo Alto, CA 94304
(877) 717-3733
TTY: (650) 724-1828

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for laboratory test(s) 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 laboratory test(s) below.

Laboratory test(s)	Reason Medicare May Not Pay:	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 laboratory test(s) 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.

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

❑ **OPTION 1.** I want the laboratory test(s) 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 laboratory test(s) 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 laboratory test(s) listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

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.

Signature:	Date:

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.

The Balanced Budget Act of 1997 requires Medicare to pay for screening Pap smears more frequently than every two (2) years for a) women at high risk for cervical or vaginal cancer, and b) women of childbearing age who have had a Pap smear during any of the three (3) preceding years that indicated the presence of cervical or vaginal cancer or other abnormalities, and c) diagnostic Pap smears.

According to CMS, the following factors place a woman in a **high risk category** for development of cervical or vaginal cancer:
- Early onset of sexual activity, defined as under 16 years of age
- Multiple sexual partners, defined as five or more in a lifetime
- History of a sexually transmitted disease, including HIV infection
- Fewer than 3 negative Pap smears within the previous 7 years
- Daughters of women who took diethylstibestrol (DES) during pregnancy

CMS defines "childbearing age" as applying to premenopausal women who, as determined by a physician or other qualified practitioner (certified nurse midwife, nurse practitioner, clinical nurse specialist or physician assistant), is of childbearing age based on her medical history or other findings.

Diagnostic Pap smears are covered under the following conditions:
- Previous cancer of the cervix, uterus or vagina that has been or is being treated
- Any abnormal findings of the vagina, cervix or uterus, ovaries or adnexa, and significant complaint by the patient related to the female reproductive system
- Any signs or symptoms that might, in the healthcare provider's judgement, reasonably be related to a gynecologic disorder

Please check the box on the test requisition that indicates the pertinent clinical information for each patient.

If Medicare determines that a particular item or service, although it would otherwise be covered, is not "reasonable and customary", under Medicare program standards, payment will be denied.

A copy of the Advance Beneficiary Notice (ABN), signed by the patient, will allow Stanford Hospital and Clinics to bill the patient if Medicare payment is denied. When ordering Pap smears, please include a signed copy of the ABN for all Medicare beneficiaries.

ABN INFORMATION

- **The ABN form is located on the reverse side of this page.**
- **Please do not detach the ABN from from the requisition.**
- **Complete the ABN and obtain the patient's signature.** ***Do not write on the ABN with the requisition pages underneath it.***