**Pathology / Cytology**

**Procedure:**

<table>
<thead>
<tr>
<th>Specimen Site:</th>
<th>Tissue or Fluid Submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
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<tr>
<td>C</td>
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<tr>
<td>D</td>
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</tr>
<tr>
<td>E</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
</tr>
</tbody>
</table>

*TIME REQUIRED for Breast Biopsy and Flow Cytometry Specimens: *Time of Collection: ___________ am/pm

**Clinical History and Diagnosis:**

**Gynecologic Specimens**

For Gynecologic Specimens

- Last Menstrual Period _____ / _____ / _____

- *Routine Z12.4* □ *Well Woman Z01.419* □ Pregnancy □ High Risk □ Diagnostic _________ □ Medicare requires ABN

**Specimen Source:**

- □ CERVICAL □ ENDOCERVICAL □ VAGINAL □ ENDOMETRIAL □ OTHER

**Clinical History:**

- □ Previous Pap Normal □ Follow Up Abnormal Pap □ Pregnant □ Postpartum
- □ Menopause/Post Menopause □ Post Menopausal Bleeding □ Abnormal Vaginal Bleeding
- □ Hysterectomy □ Supracervical Hysterectomy □ History Radiation/Chemo

**Drugs/Hormones:**

- □ None □ Birth Control □ Depo-Provera □ Estrogen □ IUD with Progesterone □ Tamoxifen □ Other

**Clinical Testing**

**Specimens Collected with Thin Prep® Pap Bottle**

- □ Pap Test ONLY 88142
- □ Pap Test with HPV 88142, 87624***
- □ Pap Test with Reflex HPV if ASCUS 88142, 87624***
- □ Pap Test with Reflex HPV if LSIL 88142, 87624***
- □ Chlamydia Only (TMA) 87491
- □ Chlamydia/Gonorrhoeae (TMA) 87491, 87591
- □ Trichomonas (TMA) 87661

- ***ALL positive high risk HPV will be reflexed to 16 18/45 genotyping 87625

**Specimens Collected with Universal Viral Transport Media**

- □ Herpes Simplex Virus I & II By PCR 87529 x 2
- □ Herpes Virus Culture Reflex To Type 87522, 87253

**Specimens Collected with E-swab** (aerobic, anaerobic, fastidious bacteria)

- □ Group B Strep (GBS) Vag/Rectal DNA Amplification 87081, 87653
- □ Vaginal Culture 87070
- □ Yeast Screen 87070

**Specimens Collected with White Top Bactiswab Culturette**

- □ Fungal Culture 87102, 87220

**Other Testing:**

- □ Pap Bottle T *C Other □ Swab # □ Bx #

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*Signifies Mandatory Requirement - please provide.  FR-51V025C (11/18)  *Ordering Provider Signature REQUIRED _______ Date: _______

Physician or Non Physician Provider Acknowledgement and Certification: Medicare claims submitted for laboratory services require that the tests be medically necessary for the diagnosis and treatment of the patient and that these services are reasonable and necessary. The medical necessity of each test ordered must be accurately documented in the patient’s medical record. It has been explained to the patient that Medicare may not cover some laboratory testing and/or screening that the physician or non physician provider believes are appropriate. An Advance Beneficiary Notice (ABN) must be signed by the patient, or an authorized person indicating their acceptance of financial responsibility for screenings and/or non covered tests. Please provide diagnostic information in the form of a valid ICD-10 code or a complete narrative diagnosis at the time of service.

The ordering provider also understands that bills will be submitted for payment to Medicare, Medicaid, all other government programs and third party payors upon the diagnosis information provided.
### PATIENT INFORMATION REQUIRED

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Sex</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Patient Phone</th>
<th>Patient SSN#</th>
</tr>
</thead>
</table>

Address: [Please Attach Copy of BOTH SIDES of Insurance Card]

**Billing Information**

- **Work Comp REQUIRED**

- **Bill To:**
  - Patient
  - Medicare
  - Client ACCT
  - Medi-Cal
  - Insurance
  - Workers Comp

**Employer Information**

- Employer Name:

- Employer Address:

**ICD-10 OR NARRATIVE DIAGNOSIS REQUIRED**

- ABN Attached: Yes
- **ICD-10#**
- **ICD-10#**
- **ICD-10#**
- **ICD-10#**

### Pathology / Cytology

**Procedures:**

- **Tissue or Fluid Submitted:**
  - A
  - B
  - C
  - D
  - E
  - F

**Specimen Site:**

**Time Required for Breast Biopsy and Flow Cytometry Specimens:**

- **Time of Collection:** ___________ am/pm

### Clinical History and Diagnosis

### Gynecologic Specimens

**Last Menstrual Period** ___________ / ___________ / ___________

- **Routine Z12.4**
- **Well Woman Z01.419**
- **Pregnancy**
- **Diagnostic**

**Specimen Source:**

- Cervical
- Endocervical
- Vaginal
- Endometrial
- Other

**Clinical History:**

- Previous Pap Normal
- Follow Up Abnormal Pap
- Post Menopausal Bleeding
- Abnormal Vaginal Bleeding
- Hysterectomy
- Supracervical Hysterectomy
- History Radiation/Chemo

**Drugs/Hormones:**

- None
- Birth Control
- Depo-Provera
- Estrogen
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- Tamoxifen
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- Fungal Culture 87102, 87220

**Other Testing:**

**LAB USE ONLY**

- Pap Bottle T °C Other
- Swab # ________
- Bx # ________

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**Date:** ___________

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FR-51V025C (11/18)