



CHECK APPROPRIATE BOX FOR BILLING  
 INSURANCE BILLING: COMPLETE SECTION 1-6 BELOW  GRANT ACCOUNT \_\_\_\_\_  
 PATIENT BILLING (SELF PAY): COMPLETE SECTION 1-2 BELOW  WHOLESALE/ACCOUNT \_\_\_\_\_

PATIENT NAME (LAST, FIRST, MI) - PLEASE PRINT			LAST	FIRST	MIDDLE	SEX <input type="checkbox"/> M <input type="checkbox"/> F
PATIENT HISTORY #	DOB	PHYSICIAN NAME (LAST, FIRST)		PHONE/PIC #		
PHYSICIAN SIGNATURE						
PATIENT LOCATION		DATE & TIME OF COLLECTION				

1. PATIENT ADDRESS (STREET OR PO BOX)		CITY/STATE	ZIP CODE
2. PATIENT PHONE #		PATIENT SOCIAL SECURITY #	PATIENT MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D RACE <input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> OTHER
GUARANTOR NAME (LEAVE BLANK IF PATIENT IS GUARANTOR)		GUARANTOR PHONE #	RELATIONSHIP TO PATIENT
GUARANTOR ADDRESS (STREET OR PO BOX)		CITY/STATE	ZIP CODE
3. MEDICARE: PRIMARY/SECONDARY	MEDICARE # & LETTER	4. MEDICAID #	STATE EFFECTIVE DATE
5. OTHER INSURER <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY		COMPANY NAME	ADDRESS PHONE #
EFFECTIVE DATE	SUBSCRIBER NAME	POLICY #	GROUP #

ICD9 CODE _____	SPECIMEN SOURCE/TEST ORDER
<b>GYN CYTOLOGY SPECIMEN SOURCE</b>	<b>NON-GYN CYTOLOGY</b>
<input type="checkbox"/> Cervix/Endocervix <input type="checkbox"/> Vaginal <input type="checkbox"/> Cervix <input type="checkbox"/> Vulva <input type="checkbox"/> Endocervix <b>TEST ORDER</b> <input type="checkbox"/> Conventional Pap Test <input type="checkbox"/> ThinPrep Pap Test <input type="checkbox"/> ThinPrep Pap with Reflex HPV Test, ASC/AGC interpretation only. <input type="checkbox"/> ThinPrep Pap with HPV Test, regardless of interpretation. <input type="checkbox"/> ThinPrep Pap with HPV Screening for Women 30 and over. [see reverse side for information]	<input type="checkbox"/> Bronchial Biopsy <input type="checkbox"/> Urine, Cath <input type="checkbox"/> Bronchial Lavage <input type="checkbox"/> Urine, Clean Catch <input type="checkbox"/> Brushings _____ <input type="checkbox"/> Urine, Ileal Conduit <input type="checkbox"/> Cyst Fluid <input type="checkbox"/> Urine, Voided <input type="checkbox"/> CSF <input type="checkbox"/> Washings _____ <input type="checkbox"/> Pericardial Fluid <input type="checkbox"/> Other _____ <input type="checkbox"/> Peritoneal Fluid <input type="checkbox"/> Pleural Fluid Special Tests/Stains: <input type="checkbox"/> AFB <input type="checkbox"/> Silver <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____ <input type="checkbox"/> Fine Needle Aspiration (source) _____

<b>PATIENT HISTORY/SYMPTOMS/COMPLAINTS/CLINICAL FINDINGS</b> Date of Onset of Current Condition: _____		
LMP DATE _____	<input type="checkbox"/> Contraception	<input type="checkbox"/> Hx of Cancer (Type _____ )
GR _____ Para _____ Ab _____	<input type="checkbox"/> Hormone Replacement Therapy	<input type="checkbox"/> Radiation Therapy (Date _____ )
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Chemotherapy (Date _____ )
<input type="checkbox"/> Post Partum	<input type="checkbox"/> Conization	<input type="checkbox"/> Other Medications or Therapy _____
<input type="checkbox"/> Perimenopausal	<input type="checkbox"/> Colposcopy & Biopsy	<input type="checkbox"/> Previous Surgery _____
<input type="checkbox"/> Postmenopausal	<input type="checkbox"/> Laser/Cryo Therapy	<input type="checkbox"/> Previous Surg Path Spec. _____
<input type="checkbox"/> Post Hysterectomy	<input type="checkbox"/> Hx of Dysplasia _____	<input type="checkbox"/> Previous Cytology Spec. _____
<b>OTHER FINDINGS:</b>		

<b>FOR LABORATORY USE ONLY</b>	
Slides Received _____	Slides Made _____ Cell Block _____ Core Needle Biopsy _____ Other _____
Special Stain(s) _____	Immunohistochemical Stain(s) _____
Gross Description: _____	CPT Codes Assigned: _____
<b>SPECIMEN/REQUISITION DEFICIENCIES</b>	<b>TECH COMMENTS:</b>
Reason(s) _____	
Resolution(s) _____	
Contact _____	

LVA049

(complete a separate request form for each specimen submitted)



#### **EXPLANATION FOR MEDICARE PAP TEST CATEGORIES:**

Medicare differentiates between screening and diagnostic Pap tests because there are statutory limitations on the frequency of reimbursement for screening Pap smears. The requesting physician is required to provide the appropriate ICD-9 code.

Diagnostic Pap Tests are performed because there are signs, symptoms or history of disease. They must meet one of the following criteria:

- The patient is being treated for cancer of the cervix, uterus or vagina, or has been treated for one of these conditions;
- The patient previously had an abnormal Pap smear;
- The physician found abnormalities of the vagina, cervix, uterus, ovaries, or adnexa; or
- The patient exhibits signs or symptoms that might, in the physician's judgement, reasonably be related to a gynecological disorder.

The ICD-9 code should indicate the medical necessity of the test based on the above criteria. Diagnostic Pap tests are generally reimbursable whenever they are ordered.

Screening Pap Tests are performed in the absence of signs and symptoms of disease and are essentially preventative in nature. Medicare will reimburse one ROUTINE screening Pap test every two years. The only exceptions to this policy are patients designated by their physician as high risk. Medicare will reimburse a HIGH-RISK screening Pap test on an annual basis for a beneficiary who is either 1) at high risk for the development of cervical or vaginal cancer or 2) is of childbearing age who has had a Pap smear during the preceding three years indicating the presence of cervical or vaginal cancer or other abnormality. HCFA lists the following as high-risk factors for cervical or vaginal cancer:

- Early onset of sexual activity (under age 16);
- Multiple sex partners (five or more in a lifetime);
- History of sexually transmitted disease (including HIV infection);
- Fewer than three negative Pap smears within the last seven years; and
- Daughters of women who took DES (diethylstilbestrol) during pregnancy.

The ICD-9 codes for ROUTINE screening Pap tests are V72.31, V76.2, V76.47, and V76.49. The ICD-9 code for HIGH-RISK screening Pap tests is V15.89. Please note that Medicare will not reimburse for more than one screening Pap test per year regardless of the patient's risk status.

#### **EXPLANATION FOR HPV TEST ORDERING**

**Reflex HPV Testing (ASC/AGC):** Based on data from the NCI-sponsored ALTS clinical trial and other studies, a reflex HPV test for a panel of "high-risk" HPV using HC II methodology is recommended as the best method to determine whether a patient with an equivocal cytology abnormality on a Pap test (ASC or AGC) is at risk for a high grade cervical lesion. For squamous abnormalities, the risk is less than 1% if the HPV test is negative. The HPV results are correlated with the Pap test results in an addendum report.

**HPV Testing Regardless of Interpretation:** Request this test to have HPV testing performed and correlated with the Pap test regardless of the cytologic interpretation. Note that in patients with LSIL, HSIL or cancer, this test is of no known triage value and is not recommended. In the setting of post treatment follow-up after ablative therapy for neoplasia, properly timed HPV testing is of value in assessing risk of recurrence or efficacy of treatment per ASCCP guidelines. The HPV results are correlated with the Pap test results in an addendum report.

**HPV Primary Screening:** In women age 30 and older, HPV testing in conjunction with cervical cytology has been shown to have superior sensitivity and negative predictive value in screening for cervical neoplasia when compared to cervical cytology alone. In these patients, the specimen vial will be referred immediately for HPV testing once the Pap test has been run. The results of these HPV tests will be reported positive or negative in a Medical Laboratories report only. They will NOT be added to the Cytopathology report.