LabCorp
INDIANA, INC.
530 North Lafayette Boulevard
South Bend, IN 46601-1098

# CYTOLOGY REQUISITION

J.L. Simpson MD
Medical Director

Client Code: ( ) Name: _____

| ✓ Dr# | Physician's Last Name, First Name | ✓ Dr# | Physician's Last Name, First Name |
|---|---|---|---|
| [ ] | _____ | [ ] | _____ |
| [ ] | _____ | [ ] | _____ |
| [ ] | _____ | [ ] | _____ |
| [ ] | _____ | [ ] | _____ |
| [ ] | _____ | [ ] | _____ |
| [ ] | _____ | [ ] | _____ |
| [ ] | _____ | [ ] | _____ |
| [ ] | _____ | [ ] | _____ |

**Signature of Ordering Provider/Authorized Signature**

_____ / /
**(Signature must be legible & include first and last name)** **Date**

**NPI**

**PATIENT INFORMATION – Please PRINT**

Name_____
Last First MI
DOB_____ SEX _____
MO / DAY / YEAR

HOSPITAL PATIENT STATUS
☐ In-Patient ☐ Out-Patient ☐ Non-Patient

**SPECIMEN COLLECTION**

Date _____ Collector's Initials_____
MO / DAY / YEAR
Time:_____ ☐ AM ☐ PM
Fasting ☐ Yes ☐ No

**BILLING**
☐ PHYSICIAN / ACCOUNT
☐ PATIENT / INSURANCE
**(SEE REVERSE)**
☐ BCCP, Alpha ID# _____
IF NO BILLING INFORMATION IS PROVIDED AND NO BOX IS CHECKED, YOUR ACCOUNT WILL BE BILLED.

**REMINDER:** IF YOU HAVE REQUESTED ANY TEST INDICATED IN **BOLD** AND NOTED WITH AN **ASTERISK (*),** THE PATIENT MAY NEED TO SIGN AND DATE THE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN). REFER TO THE SOUTH BEND MEDICAL FOUNDATION WEBSITE WWW.SBMF.ORG

**PRIORITY** ☐ **Routine** ☐ **Phone** ☐ **STAT** ☐ **Fax #** _____
**SEE ATTACHED FOR ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT**

**Performing Radiologist:** _____
**Ordering Physician:** _____

**Copy To:** _____
**Copy To:** _____

## GYNECOLOGIC CYTOPATHOLOGY

Collection Date _____ / _____ / _____
Last Menstrual Period **(REQUIRED)** _____ / _____ / _____

**SOURCE REQUIRED**
☐ Cervical, Endocervical
☐ Vaginal ☐ Other _____

☐ Pregnant
# of weeks_____
☐ IUD _____
☐ Postmenopausal
☐ Hysterectomy:
☐ Supra cervical or ☐ Total

**CLINICAL HISTORY REQUIRED**
☐ Postpartum
☐ Abnormal Bleeding
☐ High Risk Patient
☐ Hormonal Therapy

**PREVIOUS ABNORMAL HISTORY REQUIRED**
Date _____ / _____ /_____
RESULTS: ☐ ASC-US ☐ LSIL ☐ HSIL ☐ Carcinoma
High Risk HPV? ☐ Yes ☐ No
Treatment: _____

### SCREENING PAP • ✓ Test PLUS – Diagnosis

☐ **24250 Thin Prep Screen Pap***
☐ **24254 Screen Pap and HPV DNA* High risk recommended for women over age 30 depending on history**
☐ **24251 Screen Pap and HPV DNA* High Risk –if ASC-US (age 21 and over)**
☐ **24253 Screen Pap and HPV DNA High Risk* –If ASC-US or LSIL, recommended for post-menopausal women**

**DIAGNOSIS:** _____

☐ **24100 Sure Path Screen Pap***
☐ **24208 Sure Path + HPV***
☐ **24216 Sure Path + HPV if ASC***
☐ **24206 Sure Path + HPV if A/LSIL***

**or**

### DIAGNOSTIC PAP • ✓ Test PLUS – Diagnosis

☐ **24350 Thin Prep Diagnostic Pap***
☐ **24354 Diagnostic Pap and HPV DNA *High Risk**
☐ **24351 Diagnostic Pap and HPV DNA *High Risk if ASC-US**
☐ **24353 Diagnostic Pap and HPV DNA *High Risk if ASC-US or LSIL**

**DIAGNOSIS:** _____

☐ **24200 Sure Path Diag. Pap***
☐ **24204 SPDX+HPV***
☐ **24212 SPDX+HPV if ASC***
☐ **24202 SPDX+ if A/L***

## HPV, CHLAMYDIA / GC TESTING FROM PAP VIAL

| | | | |
|---|---|---|---|
| ☐ **36391** | **HPV-TP, High Risk HPV, ThinPrep Vial*** | ☐ **36392** | **HPV-SP, High Risk HPV, SurePath Vial*** |
| ☐ **36370** | **Thin Prep Chlamydia trachomatis & Neisseria gonorrhoeae by Nucleic Acid Amplification*** | ☐ **36380** | **SUREPATH Chlamydia trachomatis & Neisseria gonorrhoeae by Nucleic Acid Amplification*** |
| ☐ **36371** | **Thin Prep Chlamydia trachomatis by Nucleic Acid Amplification*** | ☐ **36381** | **SUREPATH Chlamydia trachomatis by Nucleic Acid Amplification*** |
| ☐ **36372** | **Thin Prep Neisseria gonorrhoeae by Nucleic Acid Amplification*** | ☐ **36382** | **SUREPATH Neisseria gonorrhoeae by Nucleic Acid Amplification*** |

**DIAGNOSIS:**_____ ***NOTE: Additional Charge for HPV DNA / See Reverse Side for Financial Agreement** **DIAGNOSIS:**_____

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For our locations and hours
Please visit our website @
www.sbmf.org or call us at
574-234-4176 and press 5
800-544-0925 and press 5

# INSURANCE INFORMATION

Responsible Party Name (required if patient is a minor):

Responsible Party Address:

City | State | Zip

Responsible Party Phone

( ) _____ - _____

☐ Medicare # _____

☐ Medicaid # _____ EDD _____
M/D/Y _____

☐ Primary Insurance (Complete or attach copy of insurance card.)

| | | |
|---|---|---|
| INSURANCE COMPANY NAME: | | |
| NETWORK: | | |
| CLAIMS ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| POLICY HOLDER NAME: | | D.O. B. |
| RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent | | |
| POLICY ID #: | GROUP #: | |
| EMPLOYER: | EFFECTIVE DATE: | |

☐ Secondary Insurance (Complete or attach copy of insurance card front & back.)

| | | |
|---|---|---|
| INSURANCE COMPANY NAME: | | |
| NETWORK: | | |
| CLAIMS ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| POLICY HOLDER NAME: | | D.O. B. |
| RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent | | |
| POLICY ID #: | GROUP #: | |
| EMPLOYER: | EFFECTIVE DATE: | |

**IMPORTANT**

A WRITTEN ORDER AND AN APPROPRIATE DIAGNOSIS MUST ACCOMPANY EACH LABORATORY TEST. WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDICAID REIMBURSEMENT WILL BE SOUGHT, ONLY TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT SHOULD BE ORDERED.

**MICROBIOLOGY PROTOCOL**

MICROBIOLOGY CULTURES MAY INCLUDE CHARGES FOR ONE PRIMARY SOURCE SMEAR, ONE PRIMARY CULTURE, ONE CHARGE PER ORGANISM REQUIRING IDENTIFICATION, AND ONE CHARGE PER SENSITIVITY PERFORMED. This is source specific. Refer to the fee schedule for further clarification, or call The Medical Foundation Client Services Department at (574) 236–7263 or (800) 950-7263

## ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

EVERY patient MUST read, sign, and date:

I request that payment of authorized Medicare or insurance benefits be made on my behalf to LabCorp Indiana, Inc.

I authorize any holder of medical or other information about me that pertains to the determination of payable benefits for related services to release such information to my designated insurance company and/or Centers of Medicare & Medicaid Services (CMS) and their agents.

I agree that I am fully responsible for the payment of all the designated laboratory services LabCorp Indiana, Inc. rendered to me or on my behalf. I accept responsibility for charges Medicaid does not cover when I am enrolled in a limited coverage Medicaid program.

I understand that additional testing may be performed based on my physician's request. I agree to be fully responsible for payment if my insurance plan does not cover the cost.

I also agree that if any insurance plan, except Medicaid, determines the test(s) requested to be medically unnecessary and/or an uncovered procedure(s) and denies payment to LabCorp Indiana, Inc., I accept full responsibility for payment to LabCorp Indiana, Inc.

_____ _____

Patient Signature | Date