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

_____

(Signature must be dated, legible, and include first and last name)

Date_____

PATIENT INFORMATION – Please PRINT or place label here

Name _____
Last First MI

SS#_____

DOB_____ SEX _____
MO / DAY / YEAR

SPECIMEN COLLECTION

Date: _____ (MO / DAY / YEAR)
Collector's Initials: _____
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: Tests noted with an **asterisk (*)** and in **BOLD** print may require patient signature on advance beneficiary notice (ABN) Refer to SBMF Medical Necessity Guide Book.

PRIORITY ☐ **Routine** ☐ **Phone** ☐ **STAT**
☐ **Fax#** _____

Performing Radiologist: _____
Ordering Physician: _____

Copy To: _____
Copy To: _____

GYNECOLOGIC CYTOPATHOLOGY

Collection Date _____ / _____ / _____

Last Menstrual Period (REQUIRED) _____ / _____ / _____

SOURCE REQUIRED
☐ Cervical, Endocervical
☐ Vaginal ☐ Other _____

CLINICAL HISTORY REQUIRED
☐ Pregnant
# of weeks_____
☐ IUD _____
☐ Postmenopausal
☐ Hysterectomy:
☐ Supra cervical or ☐ Total (specify)
☐ 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: _____

☐ 50512	Gynecologic Pap Test (Image guided), Liquid-based Prep	☐ 50524	Gynecologic Pap Test, Liquid-based Prep
☐ 50513	Gynecologic Pap Test (Image-Guided), Liquid-based Prep and Chlamydia/Gonococcus, NAA	☐ 50528	Gynecologic Pap Test – Age-based Guideline for Cervical Cancer (Aptima®)
☐ 50514	Gynecologic Pap Test (Image-Guided), Liquid-based Prep and Chlamydia/Gonococcus, NAA and Human Papillomavirus (HPV) (Aptima®) w/ Reflex to HPV Genotypes 16 and 18, 45	☐ 50529	Gynecologic Pap Test – Age-based Guideline for Cervical Cancer (Aptima®) and STDs
☐ 50515	Gynecologic Pap Test (Image-guided), Liquid-based Prep and Chlamydia/Gonococcus, NAA w/ Reflex to Human Papillomavirus (HPV) (Aptima®) when ASC-U	☐ 50530	Gynecologic Pap Test – Age-based Guideline for Cervical Cancer (Aptima®) Plus Chlamydia/Gonococcus
☐ 50516	Gynecologic Pap Test (Image-guided), Liquid-based Prep and Chlamydia/Gonococcus/Trichomonas, NAA	☐ 50531	Gynecologic Pap Test – Age-based Guideline for Cervical Cancer (Aptima®) Plus Chlamydia/Gonococcus/Trichomonas
☐ 50517	Gynecologic Pap Test (Image-guided), Liquid-based Prep and Chlamydia/Gonococcus/Trichomonas, NAA and Human Papillomavirus (HPV) (Aptima®) w/ Reflex to HPV Genotypes 16 and 18, 45	☐ 50844	Pap Test (Image-guided), Liquid-based Prep and hrHPV w/ HPV 16 and 18 (cobas), ThinPrep
☐ 50518	Gynecologic Pap Test (Image-guided), Liquid-based Preparation and Chlamydia/Gonococcus/Trichomonas, NAA w/ Reflex to Human Papillomavirus (HPV) (Aptima®) when ASC-U	☐ 50845	Gynecologic Pap Test (Image-guided), Liquid-based Preparation w/ Reflex to High-risk HPV (Cobas®) w/ HPV Genotypes 16 and 18 when ASC-U using SurePath™ specimen
☐ 50519	Gynecologic Pap Test (Image-guided), Liquid-based Preparation and Human Papillomavirus (HPV) (Aptima®) w/Reflex to HPV Genotypes 16 and 18,45	☐ 50846	Gynecologic Pap Test (Image-guided), Liquid-based Preparation w/ Reflex to High-risk HPV (Cobas®) w/ HPV Genotypes 16 and 18 when ASC-U
☐ 50521	Gynecologic Pap Test (Image-guided), Liquid-based Preparation w/ Reflex to Human Papillomavirus (HPV) (Aptima®) when ASC-U		

Diagnosis: _____

HPV, CHLAMYDIA / GC TESTING FROM PAP VIAL

☐ 44518	Chlamydia/Gonococcus, NAA (Aptima®)	☐ 50532	Human Papillomavirus (HPV) (Aptima®)
☐ 47224	Trichomonas vaginalis, NAA, (Aptima®)	☐ 50842	High-risk HPV w/ HPV Genotypes 16 and 18 (cobas)
☐ 47440	Chlamydia trachomatis, (Aptima®)	☐ 50843	Pap Test (Image-guided), Liquid-based Prep and hrHPV w/ HPV 16 and 18 (cobas), SurePath
☐ 47441	Neisseria gonorrhoeae, (Aptima®)	☐ 50854	Human Papillomavirus (HPV) Genotypes 16 and 18, 45 (Aptima®)
☐ 47442	Chlamydia trachomatis, Neisseria gonorrhoeae and Trichomonas vaginalis, NAA (Aptima®)		

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