First Systems & Resources, Inc. (434) 973-4152 Fax (434) 973-6892

UNIVERSITY of VIRGINIA HEALTH SYSTEM

CYTOPATHOLOGY REQUEST FORM

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 ☐ M ☐ 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 ☐ S ☐ M ☐ W ☐ D	RACE ☐ W ☐ B ☐ 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 ☐ PRIMARY ☐ SECONDARY / COMPANY NAME	ADDRESS		PHONE #
EFFECTIVE DATE / SUBSCRIBER NAME	POLICY #	GROUP #	

ICD9 CODE _____ **SPECIMEN SOURCE/TEST ORDER**

GYN CYTOLOGY

SPECIMEN SOURCE

☐ Cervix/Endocervix ☐ Vaginal
☐ Cervix ☐ Vulva
☐ Endocervix

TEST ORDER

☐ Conventional Pap Test
☐ ThinPrep Pap Test
☐ ThinPrep Pap with Reflex HPV Test, ASC/AGC interpretation only.
☐ ThinPrep Pap with HPV Test, regardless of interpretation.
☐ ThinPrep Pap with HPV Screening for Women 30 and over. [see reverse side for information]

NON-GYN CYTOLOGY

☐ Bronchial Biopsy
☐ Bronchial Lavage
☐ Brushings _____
☐ Cyst Fluid
☐ CSF
☐ Pericardial Fluid
☐ Peritoneal Fluid
☐ Pleural Fluid
☐ Sputum
☐ Urine, Cath
☐ Urine, Clean Catch
☐ Urine, Ileal Conduit
☐ Urine, Voided
☐ Washings _____
☐ Other _____

Special Tests/Stains: ☐ AFB ☐ Silver ☐ Other _____

☐ **Fine Needle Aspiration** (source) _____

PATIENT HISTORY/SYMPTOMS/COMPLAINTS/CLINICAL FINDINGS Date of Onset of Current Condition: _____

LMP DATE _____
GR ____ Para ____ Ab ____
☐ Pregnant
☐ Post Partum
☐ Perimenopausal
☐ Postmenopausal
☐ Post Hysterectomy

☐ Contraception
☐ Hormone Replacement Therapy
☐ Abnormal Bleeding
☐ Conization
☐ Colposcopy & Biopsy
☐ Laser/Cryo Therapy
☐ Hx of Dysplasia _____

☐ Hx of Cancer (Type _____)
☐ Radiation Therapy (Date _____)
☐ Chemotherapy (Date _____)
☐ Other Medications or Therapy _____
☐ Previous Surgery _____
☐ Previous Surg Path Spec. _____
☐ Previous Cytology Spec. _____

OTHER FINDINGS:

FOR LABORATORY USE ONLY

Slides Received _____ Slides Made _____ Cell Block _____ Core Needle Biopsy _____ Other _____

Special Stain(s) _____ Immunohistochemical Stain(s) _____

Gross Description: _____ CPT Codes Assigned: _____

SPECIMEN/REQUISITION DEFICIENCIES

Reason(s) _____

Resolution(s) _____

Contact _____

TECH COMMENTS:

UVA049

33095 3/07

(complete a separate request form for each specimen submitted)

UNIVERSITY of VIRGINIA HEALTH SYSTEM

Lee Street, Room 2901
Charlottesville, VA 22908
(434) 924-LABS (5227) or 1-888-882-3990

Patient Name _____ Medicare # (HICN) _____
(Print Please)

Advance Beneficiary Notice (ABN)

NOTE: You need to make a choice about receiving these laboratory tests.

We expect that Medicare will not pay for the test(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for the laboratory test(s) indicated below for the following reasons:**

- ☐ Medicare does not pay for these test(s) for your condition.
- ☐ Medicare does not pay for experimental or research use tests.
- ☐ Medicare does not pay for these tests as often as this (denied as too frequent)
- ☐ Other _____

Medicare is likely to deny payment of the following test(s) indicated.

- ☐ (Please specify)_____
- ☐ (Please specify)_____
- ☐ (Please specify)_____
- ☐ (Please specify)_____
- ☐ (Please specify)_____
- ☐ (Please specify)_____

The purpose of this form is to help you to make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

* Ask us to explain, if you don't understand why Medicare probably won't pay.
* Ask us how much these laboratory tests will cost you (**Estimated Cost: $** _____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these laboratory tests.**
I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare is making the decision.— If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I may have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these laboratory tests**
I will not receive these laboratory tests. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I will notify my doctor who ordered these tests that I did not receive them.

Date _____ **Signature of patient or person acting on patient's behalf**_____

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-L (June 2002)

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 trail 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 addended to the Cytopathology report.