Dianon PATHOLOGY
LabCorp Specialty Testing Group

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Shelton, CT 06484
800-328-2666
203-926-7100

840 Research Parkway
Oklahoma City, OK 73104
800-411-1839
405-290-4000

GYNECOLOGIC PATHOLOGY

ACCOUNT INFORMATION

ACCOUNT NO. TELEPHONE NO.

ACCOUNT NAME AND ADDRESS

REQUESTING PHYSICIAN (PLEASE PRINT) PHYSICIAN/AUTHORIZED SIGNATURE

REQUESTING PHYSICIAN NPI REFERRING PHYSICIAN (PLEASE PRINT)

PATIENT INFORMATION

CHART NUMBER

PATIENT D.O.B.

PATIENT LAST NAME FIRST NAME M.I.

STREET ADDRESS

CITY STATE ZIP CODE

SEX M ☐ F ☐

RACE MRN / PATIENT ID# PATIENT TELEPHONE NO.

BILLING INFORMATION

Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

REQUIRED ICD-CM CODE(S):

BILL: ☐ PRACTICE/FACILITY ☐ PATIENT ☐ MEDICARE ☐ MEDICAID ☐ INSURANCE ☐ REFERRAL # ____________

POLICY/ID# ____________ GROUP # ____________ 2ND INS POLICY/ID# ____________ GROUP # ____________

INSURANCE CARRIER ____________ INSURANCE CARRIER ____________

CLAIM ADDRESS ____________ CLAIM ADDRESS ____________

CITY ________ STATE ________ ZIP ________ CITY ________ STATE ________ ZIP ________

PATIENT HOSPITAL STATUS ☐ INPATIENT ☐ OUTPATIENT ☐ NON-PATIENT

INSURED'S NAME ____________ INSURED'S DOB ____________

PATIENT'S RELATIONSHIP TO INSURED: ☐ SPOUSE ☐ CHILD ☐ OTHER

CLINICAL INFORMATION

DATE OF COLLECTION: ____/____/____ # OF SPECIMENS: ____________

LMP: ____________

☐ Routine Check-up ☐ Pregnant ☐ Post-Partum
☐ Prev. Abnormal Pap ☐ Hormone Therapy ☐ Post-Menopausal
☐ I.U.D. ☐ Abnormal Bleeding
☐ Other ____________
☐ Previous Biopsy
Body Site: ____________
Type: ____________
Findings: ____________

Treatment	Date	Treatment	Date
☐ LEEP		☐ Laser	
☐ Cone Biopsy		☐ Hysterectomy	
☐ Cryotherapy		☐ Radiation	
☐ Chemotherapy			

GYN CYTOLOGY

IMAGE-GUIDED LIQUID-BASED GYN CYTOLOGY TEST REQUEST (See back for CPT codes)

☐ 193000 Pap Test@% ☐ 193069 Pap Test with Maturation Index @%

***Aptima® Options with High-Risk HPV** (*Aptima® genotyping is 16, 18/45)
☐ 199330 Pap with High-Risk HPV @%
☐ 199305 Pap with High-Risk HPV, reflex 16 & 18 @%
☐ 193157 Pap with Ct/Ng, High-Risk HPV @%
☐ 199310 Pap with Ct/Ng, High-Risk HPV, reflex 16 & 18 @%
☐ 199315 Pap with Ct/Ng/Tv, High-Risk HPV, reflex 16 & 18 @%

***Aptima® Options with Reflex to High-Risk HPV when ASC-U**
☐ 199300 Pap with reflex to High-Risk HPV if ASC-U @%
☐ 199320 Pap with Ct/Ng, reflex to High-Risk HPV if ASC-U @%
☐ 199325 Pap with Ct/Ng/Tv, reflex to High-Risk HPV if ASC-U @%

***Aptima® Options with Reflex to High-Risk HPV when ASCU, ASCH, LSIL, HSIL, AGUS**
☐ 199345 Pap with reflex to High-Risk HPV if ASCU, ASCH, LSIL, HSIL, AGUS @%
☐ 199355 Pap with Ct/Ng, reflex to High-Risk HPV if ASCU, ASCH, LSIL, HSIL, AGUS @%
☐ 199360 Pap with Ct/Ng,Tv, reflex to High Risk HPV if ASCU, ASCH, LSIL, HSIL, AGUS @%

Options with Ct/Ng
☐ 196402 Pap with Ct/Ng @% ☐ 196502 Pap with Ct/Ng/Tv @%

Conventional GYN Pap Smear
☐ 009100 Conventional Pap @% ☐ 009209 Conventional Pap w/ Maturation Index @%

Collection Method: ☐ Brush/Spatula ☐ Swab/Spatula ☐ Cervix Broom Only ☐ Spatula Only ☐ Brush Only ☐ Other: ____________

GYN Body Site: ☐ Cervix ☐ Vagina ☐ Other: ____________

Previous Cytology History
Date: ____/____/____ Diagnosis ____________

HISTOLOGY † (Gross and Microscopic Exam)

BODY SITE / SPECIMEN SOURCE

☐ Cervix ☐ Labia ☐ Vagina
☐ Endocervix ☐ Polyp ☐ Vulva
☐ Endometrium *Endometrial Dating* ☐ Yes ☐ No
☐ Other ____________

TEST REQUEST

☐ Biopsy ☐ Cone Biopsy (including LEEP)
☐ Curetting ☐ Excision
☐ Consultation (Send Path Report): Slides ________ Blocks ________
Specimen Type ____________

SPECIMEN INFORMATION

Specimen #	Body Site/Descriptor	Biopsy Method
1		
2		
3		
4		

TECHNICAL (TC)

TEST REQUEST - TECHNICAL COMPONENT (TC) Indicate Site/Source Above

☐ Biopsy - TC ☐ Cone Biopsy (including LEEP) - TC
☐ Curetting - TC ☐ Excision - TC
☐ Other TC ____________

CYTOLOGY †

TEST REQUEST

☐ FNA Site: ________ ☐ Fluids Type: ________
☐ Brushing Type: ________ ☐ Washing Type: ________
☐ Nipple Secretion: ____________
☐ Other: ____________

ADD'L TESTS

When ordering tests for which Medicare or Medicaid reimbursements will be sought, physicians should order only those tests that are medically necessary for the diagnosis or treatment of the patient.

†Separately billable stains may be added by pathologist when medically necessary to render a diagnosis.

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1A 1B 1A 1B

	Image-Guided Cytology Options★		Liquid-Based Cytology Options★
	Test No.	CPTs	
Pap Test	193000	88175/G0145	Please refer to https://www.Labcorp.com/test-menu/search
Options with High-Risk (hr) HPV mRNA			
Pap with hr HPV	199330	88175/G0145, 87624	
Pap with hr HPV, rfx 16 and 18/45•	199305	88175/G0145, 87624•	
Pap with Ct/Ng, hr HPV	193157	88175/G0145, 87491, 87591, 87624•	
Pap with Ct/Ng, hr HPV, rfx 16 and 18/45•	199310	88175/G0145, 87491, 87591, 87624•	
Pap with Ct/Ng/Tv, hr HPV	199328	88175/G0145, 87591, 87491, 87661, 87624•	
Pap with Ct/Ng/Tv, hr HPV, rfx 16 and 18/45•	199315	88175/G0145, 87491, 87591, 87624, 87661•	
Options with Reflex to High-Risk (hr) HPV mRNA when ASC-U			
Pap with rfx to hr HPV ASC-U•	199300	88175/G0145•	
Pap with Ct/Ng, rfx to hr HPV ASC-U•	199320	88175/G0145, 87491, 87591•	
Pap, with CT/NG rfx hr HPV, ASC-U, rfx to 16 and 18/45	199354	88175/G0145, 87491, 87591, 87624•	
Pap with Ct/Ng/Tv, rfx to hr HPV ASC-U•	199325	88175/G0145, 87491, 87591, 87661•	
Pap with CT/NG/Tv, rfx to hr HPV ASC-U, rfx to 16 and 18/45	199348	88175/G0145, 87491, 87591, 87624, 87661•	
Options with Reflex to High-Risk (hr) HPV mRNA when ASCU, ASCH, LSIL, HSIL, AGUS			
Pap with rfx to hr HPV ASCUS,SIL,AGUS•	199345	88175/G0145•	
Pap with Ct/Ng, rfx to hr HPV ASCUS, SIL, AGUS•	199355	88175/G0145, 87491, 87591•	
Pap with Ct/Ng/Tv, rfx to hr HPV ASCUS, SIL, AGUS•	199360	88175/G0145, 87491, 87661, 87591•	
Options with Ct/Ng/Tv			
Pap with Ct/Ng	196402	88175/G0145, 87491, 87591	
Pap with Ct/Ng/Tv	196502	88175/G0145, 87491, 87591, 87661	

★ = Additional charge for physician-reviewed Pap Tests 88141/G0124/P3001 • = Additional charge(s) and CPT code(s) if reflex testing performed

To order non-guided liquid-based GYN cytology testing, please write the test number in the "ADD'L TESTS" section on the front of this form.

B-1A

The CPT code(s) listed here are in accordance with the current edition of Physicians' Current Procedural Terminology, a publication of the American Medical Association. CPT codes are provided here for the convenience of our clients; however, correct coding often varies from one carrier to another. Consequently, the codes presented here are intended as general guidelines and should not be used without confirming with the appropriate payer that their use is appropriate in each case. All laboratory procedures will be billed to third-party carriers (including Medicare and Medicaid) at fees billed to patients and in accordance with the specific CPT coding required by the carrier.

Determining Necessity of Advance Beneficiary Notice of Non-coverage (ABN) Completion*

1. **Diagnose.** Determine your patient's diagnosis.
2. **Document.** Write the diagnosis code(s) on the front of this requisition.
3. **Verify.** Determine if the laboratory test(s) ordered for the patient is subject to Local Coverage Determination or National Coverage Determination. This information can be located in the policies published by your Medicare Administrative Contractor (MAC), CMS, or www.Labcorp.com/MedicareMedicalNecessity.
4. **Review.** If the diagnosis code for your patient **does not** meet the medical necessity requirements set forth by Medicare or the test(s) is being performed more frequently than Medicare allows, an ABN should be completed.

*An ABN should be completed for all tests that are considered investigational (experimental or for research use) by Medicare.

How to Complete an Advance Beneficiary Notice of Non-coverage (ABN)

Medicare is very specific in requiring that all of the information included on the ABN be completed. Additionally, Labcorp requests that the specimen number or bar code label be included on the form. To be valid an ABN must:

1. Be executed on the CMS approved ABN form (CMS-R-131)
2. Identify the Medicare Part B Beneficiary, using the name as it appears on the patient's red, white and blue Medicare card
3. Indicate the test(s)/procedure(s) which may be denied within the relevant reason column
4. Include an estimated cost for the test(s)/procedure(s) subject to the ABN
5. Have 'Option 1', 'Option 2', or 'Option 3' designated by the beneficiary
6. Be signed **and** dated by the beneficiary or his/her representative **prior to** the service being rendered

Symbols used to designate Medicare medical review as of 10/01/2020

@ = Subject to Medicare medical necessity guidelines.
% = Subject to Medicare frequency guidelines.
# = Medicare deems investigational. Medicare does not pay for services it deems investigational.

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