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5/8" from top
Use with doc id 041670999 **Label Area**

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Patient's Name (Last)		(First)	(MI)	Sex	MO	DAY	YR	Collection Time	AM	PM	MO	DAY	YR		
Physician's Name				NPI/UPIN		Patient's SS#			Patient ID#						
ICD-9 Code(s) Diagnosis/Sign and Symptoms															
Medicare #				<input type="checkbox"/> Primary <input type="checkbox"/> Secondary		Medicaid #			Eff. Date						
Patient Address						City			State		Zip		Phone		
Responsible Party (If different than Patient)						City			State		Zip		Phone		
Address of Responsible Party						City			State		Zip				
Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				Insurance Company Name				<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Plan		Member #			Group #		
Company Address				Physician ID #		City			State		Zip				
Employer Name						Insured SS#			Workers Comp		<input type="checkbox"/> Yes <input type="checkbox"/> No				

Please Submit a separate ABN (Advanced Beneficiary Notice) when ordering tests/procedures that do not pass Medical Necessity Screening.
#: Frequency limit @: Medicare specific limited coverage *: Investigational use per Medicare

Note: Physicians should only order tests which are medically necessary for the treatment of the patient when Medicare and Medicaid are to be billed for services. Please label all specimens/slides appropriately.

GYN-CYTOLOGY	NON-GYN CYTOLOGY	HISTOLOGY
Pap Smear (Conventional) 1 slide <input type="checkbox"/> 88164 @ #P3000#	<input type="checkbox"/> Breast Discharge L or R <input type="checkbox"/> Bronchial Washing <input type="checkbox"/> Brushing	Tissue Source: <input type="checkbox"/> Curettage Site: <input type="checkbox"/> Biopsy Site:
Liquid Based Pap Smear <input type="checkbox"/> 88142 @ #G0123# <input type="checkbox"/> Reflex to High Risk HPV when ASC-US will add 87621 w/reflex <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL Check all applicable boxes	Site: <input type="checkbox"/> Sputum <input type="checkbox"/> Pleural Fluid L or R <input type="checkbox"/> Abdominal Fluid <input type="checkbox"/> Urine <input type="checkbox"/> Voiced <input type="checkbox"/> Catheterized <input type="checkbox"/> Fine Needle Aspirate	<input type="checkbox"/> Excision Site: # Container Sent # Received Preoperative Diagnosis:
Source <input type="checkbox"/> Cervical <input type="checkbox"/> Endocervical <input type="checkbox"/> Vaginal	Source: <input type="checkbox"/> Misc. Smear <input type="checkbox"/> Other Source:	Postoperative Diagnosis:
Required Information Date LMP _____ Menopause Y/N Previous Treatment <input type="checkbox"/> None <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Colpo/Biopsy <input type="checkbox"/> Subtotal Hysterectomy <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Other Date/Result _____	Patient History:	Clinical Notes:
Mark all that apply <input type="checkbox"/> Pregnant <input type="checkbox"/> Endocrine Therapy <input type="checkbox"/> Lactating <input type="checkbox"/> Postmenopausal <input type="checkbox"/> Birth Control <input type="checkbox"/> Postpartum <input type="checkbox"/> HRT <input type="checkbox"/> IUD	Clinical Notes:	Cytology Sent also: Y or N LMP if GYN ____ / ____ / ____
Date and Diagnosis of previous Cytology/Histology: Previous Biopsy Y or N, If yes done at UIMC Reference Laboratory Y or N Note: Additional charges apply for physician reviewed Pap Smears 88141 @ / P3001#		Additional Tests/Instructions:

LAB USE ONLY

Case# _____ TIQ _____ CB Code _____ MR# _____

STANSET®
Standard Register®

Third Copy - Client

Second Copy - Lab

First Copy - Lab

MEDICAL NECESSITY INFORMATION

Medicare does not pay for routine screenings or annual physicals and will not pay for any test deemed not "medically necessary." Pap smears are allowed at a frequency of once every two years for healthy women and once every twelve months for women at high risk. Please refer to the specific guidelines issued by your carrier.

CPT CODES

Pap Smears, Diagnostic @	88141-88155, 88164-88167
Pap Smears, Screening #	P3000, P3001, G0123, G0124 G0141, G0145, G0147, G0148

Please submit a separate ABN if:

The patient is covered by Medicare and the diagnosis given (ICD-9 code) is not a covered ICD-9 code established by the Medicare Carrier(@) and/or the test/procedure exceeds frequency limitations(#). The patient may also be responsible for an additional charge if a Pathologist interprets the Pap Smear. The medical necessity guidelines stated above and ABN submission if applicable apply to these CPT codes also.

The ICD-9 Code must be provided by the ordering physician or his/her authorized designee. Listed below are the most common used ICD-9 codes for diagnostic and screening Pap Smears. These codes are provided only as a convenience, always consult the official ICD-9 CM to ensure accurate code selection.

V15.89:	Other specified personal history presenting hazards to health, other
V76.2:	Special screening exam for malignant neoplasms, cervix
V76.47:	Special screening exam for malignant neoplasms, vaginal
V76.49:	Special screening for malignant neoplasms, other sites
V15.89:	High risk cervical screening
V22.2:	Pregnancy
616.0:	Cervicitis
616.0:	Vaginitis
626.8:	Abnormal bleeding
079.4:	Human Papilloma Virus
180.0:	Malignant neoplasm, cervix
622.1:	Dysplasia, cervix
623.0:	Dysplasia, vagina
627.1:	Postmenopausal bleeding
627.3:	Atrophic vaginitis
795.00:	Nonspecific abnormal Pap Smear of cervix, unspecified

"The ordering of medically unnecessary testing for Medicare of Medicaid patients may result in significant fines and penalties under the Civil False Claims Act"

SCREENING FOR MEDICAL NECESSITY AND OBTAINING AN ABN (Advanced Beneficiary Notice)

- * Determine your patient's diagnosis and reason for the test(s) you are about to order
- * Translate signs and symptoms into ICD-9 codes to the highest specificity and document on front of requisition.
- * Determine if the test is subject to local medical review policy.
- * If the diagnosis code for your patient does not meet the requirements outlined by the Medicare carrier or the test (s) is/are being performed more frequently than the carrier allows, an ABN should be completed prior to the procedure being performed.

NOTE: If a test is considered investigational or for research purposes by Medicare, an ABN should be completed.

COMPLETING THE ABN

To be considered a valid ABN the following criteria must be met:

- * The CMS approved ABN form must be used.
- * Document patient's Medicare Part B Identification number and Beneficiary Information.
- * Specify the test/procedure(s) which may be denied along with the appropriate reason.
- * Have patient/beneficiary choose Option 1 or Option 2.
- * Have ABN signed and dated by the patient/beneficiary or his/her designee prior to any procedure being performed.

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