Marin Medical Laboratories
An Affiliate of PathGroup
1615 HILL ROAD, SUITE C
NOVATO, CA 94947-4338

REQUESTING PHYSICIAN OR CLINIC: **CC:**

Date Specimen Collected	Patient Name (Last)	(First)	(MI)
Date of Birth	Social Security Number	Sex	Phone Number
Address	City	State	Zip Code

COMPLETE BILLING INFORMATION MUST BE BELOW OR ATTACHED - PATIENT IS BILLED WHEN NOT PROVIDED!

Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent	Responsible Party Name / Address		
PRIMARY Insurance Name / Address		**SECONDARY** Insurance Name / Address	
Policy Number	Group Number	Policy Number	Group Number

GYN CYTOLOGY DATA

This information is necessary for accurate interpretation

Date of LMP (required): _____ ☐ Abnormal Bleeding

Date of Last Pap: _____ **Results:** _____

On Hormones: ☐ Yes ☐ No If Yes, Type: _____

☐ Pregnant ☐ Post Partum ☐ Post / Perimenopausal

Pertinent Clinical Data: _____

History of Surgery: ☐ Yes ☐ No If Yes, Type: _____

Contraception: ☐ BCP ☐ IUD ☐ BTL

Other: _____

TYPE OF PAP TEST

Check one (required): ☐ **NON-MEDICARE** ☐ **MEDICARE** **Specimen Source:** ☐ **Vaginal** ☐ **Cervical** ☐ **Endocervical** ☐ **Other** _____

☐ **Routine Gyn** - Abn Findings (Z01.411) ☐ **Routine Gyn** - No Abn Findings (Z01.419) ☐ **Routine Screen** - Cervix (Z12.4) ☐ **Routine Screen** - Vaginal (Z12.72)

☐ **High Risk** - Exposure to Bodily Fluids (Z77.21) ☐ **Diagnostic** *(ICD code **required**)* _____

☐ **High Risk** - History of Treatment (Z92.89) ☐ **Non-Covered Services** *(Signed ABN **required**)*

Pap Test: ☐ **ThinPrep Pap Test** ☐ **ThinPrep Pap Test** *without* Reflex Chlamydia if under Age 26 ☐ **No Pap**

Medicare will only pay for reasonable and necessary tests and for a screening test every two (2) years. In the event the patient has more than one screening in two years, the patient is required to sign an ABN. The ABN form is on the reverse side of the top copy of this requisition. A diagnostic test may be ordered once every 12 months if the test is associated with one of the risk factors. An appropriate diagnosis code must be specified for a diagnostic test. Please indicate the risk factor and diagnosis code.

GYN CYTOLOGY

HPV DNA Assay (ThinPrep)
☐ HPV Assay
☐ HPV Assay IF Pap is ASCUS
☐ HPV Genotype 16 18/45
ICD Code _____

☐ **Chlamydia trachomatis**
ThinPrep/Urine/Aptima
ICD Code _____

☐ **Neisseria gonorrhoeae**
ThinPrep/Urine/Aptima
ICD Code _____

☐ **Trichomonas vaginalis**
ThinPrep/Urine/Aptima
ICD Code _____

NON-GYN CYTOLOGY

☐ **Urine** ☐ Voided ☐ Catheterized ☐ Bladder Washing

☐ **Nipple Discharge** ☐ Left ☐ Right

☐ **Rectal / Anal**

☐ **Sputum**

☐ **Other** _____ *ICD Code* _____

***** LAB USE ONLY *****

SURGICAL PATHOLOGY / HISTOLOGY / FNA

Clinical Data / Diagnosis: _____

Operative Procedure: _____ *ICD Code(s)* _____

Specimen Sites: _____ _____ _____ _____

_____ _____ _____ _____

NOTE: *Additional space for notes and/or drawing is available at the bottom of the reverse side of this form.* ☐ FAX RESULTS TO _____

MARIN MEDICAL LABORATORIES ▪ 1615 HILL ROAD, SUITE C, NOVATO, CA 94947-4338 ▪ (415) 209-6042

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the checked items below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the checked items below.

Checked Items Only:	Reason Medicare May Not Pay:	Est. Cost
☐ Routine Screening Pap Test	Medicare only pays for this test once every 2 years.	$ 36.34
☐ HPV High Risk Screening Test – (to include HPV 16 18/45 if needed)	Medicare may not pay for this test for your condition.	$ 48.14 (+ $ 48.14)

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked items listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the checked items listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the checked items listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the checked items listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date: