DPMG CYTOLOGY/MOLECULAR TESTING REQUISITION FORM

DIAGNOSTIC PATHOLOGY MEDICAL GROUP, INC.

CAP ACCREDITED

Customer Service and Courier Pickup
916-446-0424; Toll-free 800-464-0424
FAX 916-446-9330 www.dpmginc.com
3301 C Street, #200E, Sacramento, CA 95816

Form completed by: _____

Please fill out this form completely and place completed specimen label sticker on each container

Additional Copies of Report To (Name and Address): _____

Patient Name: Last, First			Date Specimen Taken
Patient Address	City	Zip Code	Telephone Number
Date of Birth	Age	Sex	MRN

INSURANCE ☐ Copy of insurance card(s) attached ☐ Cash pay patient

(Signed ABN Required for Medicare Patients. Please see reverse side for ABN)

CERVICAL CANCER SCREENING

☐ **PAP** **Source:** ☐ **Vaginal** ☐ **Cervical** ☐ **Endocervical**

☐ HPV regardless of Pap result or age
☐ HPV if Pap is ASCUS/ASC-H
☐ HPV if Pap is Abnormal
☐ HPV only (no Pap)

→ ☐ Reflex HPV Genotyping 16, 18/45

FOLLOW ACOG AGE RELATED TESTING GUIDELINES

☐ Age 21-24 Pap and CT/NG, Reflex HPV if Pap ASCUS
Age 25-29 Pap with reflex HPV if Pap ASCUS
Age 30-65 Pap with HPV (co-testing)
Pap neg & HPV pos, reflex HPV 16, 18/45
Age 66+ Pap only

GYN HISTORY

LMP Date _____

☐ Post Partum
☐ Post/Peri Menopausal
☐ Postmenopausal Bleeding
☐ Contraceptive
☐ Pregnant
☐ IUD
☐ Other_____

Clinical Diagnosis: _____

Diagnostic Code(s): _____
(Identifying a code does not constitute an order)

Screen for Malig Neo	Z12.4	Vaginitis	N76.0
Gyn exam w/o abnormality	Z01.419	HPV Screening	Z11.51
Non-Inflammatory Vag Disorders	N89.8		
Screening for Infections w/ Sexual Mode of Transmission			Z11.3

MOLECULAR TESTING

Pap Vial, Aptima Swab or Urine Transport Tube

☐ Chlamydia
☐ Gonorrhea
☐ Trichomonas
> Source: _____

Aptima Swab Only

☐ Vaginitis: CV (Candida species & C. Glabrata) BV (Gardnerella & Lactobacillus) & Trich
☐ HSV 1 & 2
☐ Mycoplasma genitalium (urine to be acceptable)

***BD Affirm Swab** (72 hr viability)*

☐ Vaginitis: Candida, Gardnerella, Trich

URINE CYTOLOGY/FISH (UroVysion) - Please check one

☐ Cytology ☐ Cytology/FISH ☐ Cytology/reflex FISH (atypical results) ☐ FISH only

Diagnostic Code(s): _____

Patient full name required - Place completed specimen label sticker on each container

Name _____ (Last/First)
Date _____
Specimen C00724121-1

Name _____ (Last/First)
Date _____
Specimen C00724121-2

C00724121-3

Rev. 04/2024

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ 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 **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
❒ 88142 Thin Prep Pap Smear	Medicare does not pay for this test as often (denied as too frequent)	$55.00
❒ 88175 Thin Prep Pap Smear, automated screening		$64.47
❒ 88164 Conventional Pap Smear		$31.00
❒ 88141 Path Screening / Atypical		$54.85

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 **D.** _____ 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.

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

☐ **OPTION 1.** I want the **D.** _____ 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 **D.** _____ 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 **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. 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.

I. Signature:	J. Date:

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