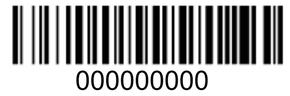
MediPath
PATHOLOGY SERVICES

4665 Ponce De Leon Blvd., Coral Gables, FL 33146
Telephone 786-464-0749 • Fax 786-953-5342

GYNECOLOGIC REQUISITION



PATIENT INFORMATION

LAST NAME	FIRST NAME	MI

DATE OF BIRTH	MRN/PT.CHART#	SEX ☐ Male ☐ Female

STREET ADDRESS

CITY	STATE	ZIP

HOME PHONE #	WORK PHONE #

CLIENT INFORMATION

LLC ACCOUNT #	NAME OF LLC	PHONE # FAX #

ORDERING PHYSICIAN / NPI #

CLIENT ADDRESS	CITY / STATE / ZIP

DATE COLLECTED	TIME COLLECTED	☐ AM ☐ PM

ICD-10 CODE(S):

INSURANCE INFORMATION

For Medicare patients please complete an ABN “Advanced Beneficiary Notice”, see reverse

PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
STREET ADDRESS	CITY / STATE / ZIP	STREET ADDRESS	CITY / STATE / ZIP
GROUP NUMBER	POLICY NUMBER	GROUP NUMBER	POLICY NUMBER
NAME OF POLICY HOLDER		NAME OF POLICY HOLDER	

CLINICAL INFORMATION

Last Menstrual Period: ___/___/_____ ☐ AUB (☐ Menorrhagia ☐ Metrorrhagia ☐ Both) ☐ Postmenopausal: date: ___/___/_____
☐ Lactating/Postpartum ☐ Pregnant Weeks: _____ ☐ Hormone Therapy (☐ in use: Contraceptives/Depo/Norplant/Other) ☐ IUD ☐ DES
☐ Clinically Apparent Infection ☐ Suspicious lesion ☐ History of Malignancy: Radiation or Chemo (circle if apply)
☐ Abnormal GYN PAP test date: ___/___/_____ Treatment: _______________________ ☐ Surgical History: Type: _______ Date: ___/___/_____
☐ 1st degree family history of malignancy (before 50 years of age in family member): _________

CURRENT/RELEVANT CLINICAL INFORMATION: ☐ Clinically Apparent Infection ☐ Mass, features:_______________________________

SOURCE

SOURCE(S): ☐ Perineum ☐ Vulva ☐ Vagina ☐ Vaginal Cuff ☐ Cervix ☐ Endocervix ☐ Ectocervix ☐ Uterus/Endometrium ☐ POCs ☐ Fallopian Tube
☐ Ovary ☐ Skin ☐ Soft Tissue ☐ Abdomen/Peritoneal/Inguinal ☐ Foreign body ☐ Other: ____________________

GYN-CYTOLOGY

☐ 201-PAP
☐ 202-PAP + HPV
☐ 203-PAP + HPV Reflex to HPV Geno
☐ 204-PAP Reflex HPV if ASCUS
☐ 205-PAP Reflex HPV if ASCUS, Reflex HPV Geno
☐ 206-PAP Reflex HPV if ABNORMAL
☐ 207-PAP Reflex HPV if ABNORMAL, Reflex HPV Geno
☐ 211-PAP (Non-Imaged)

MOLECULAR MICROBIOLOGY

GYN: ☐ CT (Chlamydia) ☐ CT/NG (Chlamydia/N. Gonorrhea) ☐ BV (Bacterial Vaginosis) ☐ CV (Candida) ☐ CV/TV (Candida/Trichomonas)
☐ TV (Trichomonas) ☐ HSV 1 & 2 (Herpes Simplex Virus 1 & 2) ☐ CT/NG (Chlamydia/N. Gonorrhea) *on **urine** yellow Aptima* ☐ Group B Streptococcal (GBS)

HISTOLOGY & NON-GYN CYTOLOGY

PROCEDURE: ☐ Core Biopsy ☐ Punch biops ☐ Incisional biopsy ☐ Excision ☐ Brushing ☐ Curetting ☐ Removal/Extraction/Passage
☐ Ectomy ☐ Piecemeal Ectomy ☐ Ligation ☐ Herniorrhaphy ☐ LEEP/Conization ☐ Ligation ☐ Hysterectomy
☐ Oophorectomy ☐ Salpingectomy ☐ Fine Needle Aspiration (FNA) ☐ Fluid aspiration

Laterality	Source	Oriented with Sutures	Laterality	Source	Oriented with Sutures
A. ☐ Right ☐ Left		☐	**C.** ☐ Right ☐ Left		☐
B. ☐ Right ☐ Left		☐	**D.** ☐ Right ☐ Left		☐
Others:			Others:		
Others:			Others:		

Note: when ordering tests for which Medicare reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient.

Physician Signature: ______________________________ **Date:** ______________

A 000000000	**B** 000000000	**C** 000000000	**D** 000000000
Patient Name / D.O.B.	Patient Name / D.O.B.	Patient Name / D.O.B.	Patient Name / D.O.B.
E 000000000	**F** 000000000	**G** 000000000	**H** 000000000
Patient Name / D.O.B.	Patient Name / D.O.B.	Patient Name / D.O.B.	Patient Name / D.O.B.

A. Notifier:

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

Advance Beneficiary Notice of Non-coverage (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**
☐ Pap Smear – 88175 (G0145)	Denied as too frequent	$50.00
☐ HPV - 87624 (G0476)	Not covered as a yearly screen	$75.00

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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