MediPath
PATHOLOGY SERVICES

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

GYNECOLOGIC REQUISITION

000000000

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	
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

☐ Pap (Thin Prep)
☐ Pap w/ High-Risk HPV (Co-test)
☐ Pap w/ HPV, reflex to Genotype (16/18/45)
☐ Pap reflex HPV if ASCUS
☐ Pap reflex HPV if ASCUS, reflex to Genotype (16/18/45)
☐ Pap reflex to HPV if Abnormal
☐ Pap reflex to HPV if Abnormal, reflex to Genotype (16/18/45)
☐ Pap, Anal
☐ HPV Only (E6/E7 mRNA)
☐ HPV Genotype (16/18/45)
☐ HPV reflex to Genotype (16/18/45)

MOLECULAR MICROBIOLOGY

GYN:

☐ Chlamydia trachomatis (CT), PCR
☐ Neisseria Gonorrhea (NG), PCR
☐ Trichomonas (TV), PCR
☐ Candida Vaginitis (CV), PCR
☐ Bacterial Vaginosis (BV), PCR
☐ Chlamydia Trachomatis/Neisseria Gonorrhoeae (CT/NG), PCR
☐ Vaginitis Panel (BV, CV, TV), PCR
☐ Vaginitis+ Panel (BV, CV, TV, CT, NG), PCR
☐ Group B Streptococcus (GBS), PCR
☐ Herpes Simplex Virus (HSV) 1/2 Panel, PCR
☐ Mycoplasma Genitalium (M. Gen), PCR
☐ Mycoplasma Genitalium/ Ureaplasma, PCR (note: send two swabs)

HISTOLOGY & NON-GYN CYTOLOGY

PROCEDURE: ☐ Core Biopsy ☐ Punch Biopsy ☐ 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 Patient Name D.O.B.	**B** 000000000 Patient Name D.O.B.	**C** 000000000 Patient Name D.O.B.	**D** 000000000 Patient Name D.O.B.
E 000000000 Patient Name D.O.B.	**F** 000000000 Patient Name D.O.B.	**G** 000000000 Patient Name D.O.B.	**H** 000000000 Patient Name D.O.B.

MediPath
PATHOLOGY SERVICES
4665 Ponce De Leon Blvd
Coral Gables, Florida 33146

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
___ Chlamydia - 87491	Denied as too frequent	$35.09
___ Gonorrhea - 87591	Denied as too frequent	$35.09

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 may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.