


# CYTOPATHOLOGY SERVICES

 <p style="text-align: center;"> <b>Pathology Laboratories</b>  <b>(804) 828-PATH (7284)</b> </p>		<b>ACCOUNT INFORMATION</b>			<b>ATTACH ONE LABEL TO EACH SPECIMEN</b>		
MEDICAL RECORD NUMBER: <b>LAB USE ONLY</b>		SSN:					
PATIENT NAME: LAST,		FIRST		MI			
ADDRESS:			APT #/ ROOM #:	DOB:	GENDER:		
CITY:	STATE:	ZIP:	PHONE:	AGE:	RACE:		
YRS _____	MOS _____	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	<input type="checkbox"/> BLACK	<input type="checkbox"/> WHITE	<input type="checkbox"/> OTHER	
INSURANCE CO. NAME:			ADDRESS:				
SUBSCRIBER NO.:		GROUP NO.:		SUBSCRIBER: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER POLICYHOLDER NAME _____			
MEDICARE NO.:			<input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY	MEDICAID NO.:			
<b>FOR OUTPATIENTS ONLY:</b> IS THERE A PLANNED HOSPITAL ADMISSION WITHIN THE NEXT THREE DAYS? <input type="checkbox"/> NO <input type="checkbox"/> YES, IF YES PROVIDE NAME OF HOSPITAL: _____ <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT							
SPECIMEN DATE:	COLLECTION TIME:	<input type="checkbox"/> AM <input type="checkbox"/> PM	24 HOUR UR TOTAL VOL: _____ ML	INITIALS: _____	<b>PHYSICIAN:</b>		
VCUHS ACCESSION # <b>LAB USE ONLY</b>		IF REFERRAL OR PRE-AUTHORIZATION IS REQUIRED PLEASE ATTACH COPY OF INSURANCE CARD & REFERRAL.			PLEASE SEND COPY OF REPORT TO: FACILITY: _____ PHYSICIAN: _____		
		REFERRAL #					
		AUTHORIZATION					
<b>Non-Gynecological Services</b>			<b>DX CODE</b>		<input type="checkbox"/> 1510 OR Client: Office Chart # _____		
<input type="checkbox"/> Body Cavity / Fluid Washing					<b>IMPORTANT CLINICAL HISTORY</b>  <div style="font-size: 2em; opacity: 0.5; transform: rotate(-45deg); position: absolute; top: 50%; left: 50%;">THIS FIELD REQUIRED</div>		
<input type="checkbox"/> CSF							
<input type="checkbox"/> Fine Needle Aspiration: Source _____							
<input type="checkbox"/> Nipple Discharge							
<input type="checkbox"/> Ocular Cytology							
<input type="checkbox"/> Oral Cavity Cytology (Direct Smear)							
<b>Respiratory Cytology</b>							
<input type="checkbox"/> Bronchial Brushing							
<input type="checkbox"/> Bronchial Washing							
<input type="checkbox"/> Bronchoalveolar Lavage (BAL)							
<input type="checkbox"/> Sputum Cytology							
<b>Urinary Cytology</b>					Other: _____ _____ _____		
<input type="checkbox"/> Bladder Washing							
<input type="checkbox"/> Urethral Cytology							
<input type="checkbox"/> Urine, Catheterized							
<input type="checkbox"/> Urine, Voided					Date of LMP: _____		
<b>Gynecological Cytology Services</b>							
<input type="checkbox"/> Pap Smear (1 Slide)					Radiation Therapy: Date: _____ Type: _____ Amount: _____		
<input type="checkbox"/> Pap Smear (2 Slide)							
<input type="checkbox"/> Liquid Based Pap (Surepath-Blue Cap Vial)							
<input type="checkbox"/> HPV Hybrid Capture (Reflex with ASCUS)							
<input type="checkbox"/> HPV Hybrid Capture (DNA Assay-any diagnosis)							
<input type="checkbox"/> HPV Hybrid Capture Only (Blue Cap Vial)					Endocrine Therapy: _____		
<b>All shaded area information must be completed. Complete all pertinent clinical information and history with sample submission.</b>							
<b>MEDICARE ADVANCE BENEFICIARY NOTICE - SCREENING PAP SMEARS</b>							
Because the screening Pap Smear is a Medicare Frequency - Limited Service the ABN may be used routinely by having the Medicare Beneficiary Sign either of the two applicable agreements shown below. Medicare will only pay for services that it determines to be 'reasonable and necessary' under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare programs, Medicare will deny payment for a <b>Screening Pap Smear if you have had one during the last three (3) years.</b>							
<b>BENEFICIARY AGREEMENT:</b> "I have been notified by my <i>physician/laboratory</i> that Medicare will deny payment for a <b>Screening Pap Smear if I have had one during the last three (3) years.</b> I believe that I have not had / have had ( <b>CIRCLE ONE</b> ) a <b>Screening Pap Smear during the last three (3) years.</b> If I am mistaken and Medicare denies payment, I agree to be personally and fully responsible for payment.							
Beneficiary Signature _____							

ORIGINAL