

CLINICAL PATHOLOGY ASSOCIATES

1150 N. 18th St. Ste. 102 • Abilene, TX 79601 • 325-670-6500 • 1-800-478-9341

www.clinicalpathologyassociates.com

Patient Name: Last _____ First _____ MI _____					
Patient SS#: _____ Phone # _____					
Date of Birth: _____ Sex: _____ Date Collected: _____ Chart # _____					
Requesting Physician REQUIRED	Hospital / Clinic REQUIRED <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;">BILLED TO</td> <td style="width: 33%;"> <input type="checkbox"/> AETNA <input type="checkbox"/> BC/BS <input type="checkbox"/> CIGNA <input type="checkbox"/> FIRST CARE </td> <td style="width: 33%;"> <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE* <input type="checkbox"/> PHYSICIAN/CLINIC <input type="checkbox"/> PATIENT </td> <td style="width: 33%;"> <input type="checkbox"/> UHC <input type="checkbox"/> OTHER INS. </td> </tr> </table>	BILLED TO	<input type="checkbox"/> AETNA <input type="checkbox"/> BC/BS <input type="checkbox"/> CIGNA <input type="checkbox"/> FIRST CARE	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE* <input type="checkbox"/> PHYSICIAN/CLINIC <input type="checkbox"/> PATIENT	<input type="checkbox"/> UHC <input type="checkbox"/> OTHER INS.
BILLED TO	<input type="checkbox"/> AETNA <input type="checkbox"/> BC/BS <input type="checkbox"/> CIGNA <input type="checkbox"/> FIRST CARE	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE* <input type="checkbox"/> PHYSICIAN/CLINIC <input type="checkbox"/> PATIENT	<input type="checkbox"/> UHC <input type="checkbox"/> OTHER INS.		

PLEASE COMPLETE INFORMATION BELOW

Patient Address REQUIRED	City, State, Zip REQUIRED
Medicare/Medicaid/Insurance Policy #	Group
Insured Name (Attach Card) Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent REQUIRED	Insured Employer REQUIRED
Insurance Co. Name & Address REQUIRED	City, State, Zip REQUIRED

NON-GYN-CYTOLOGY	GYN-CYTOLOGY
-------------------------	---------------------

<input type="checkbox"/> Abdominal Fluid	SOURCE CHECK (✓)	LMP ____ / ____ / ____ <small>LAST MENSTRUAL PERIOD</small>
<input type="checkbox"/> Bladder Washings	<input type="checkbox"/> Cervical/Endocervical <input type="checkbox"/> Vaginal Cuff <input type="checkbox"/> Other _____	

TESTS

<input type="checkbox"/> Breast Aspiration <input type="checkbox"/> Breast Discharge <input type="checkbox"/> Bronchial Brushing <input type="checkbox"/> Bronchial Washing <input type="checkbox"/> Esophageal Brushing <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Misc. Fluid <input type="checkbox"/> Synovial <input type="checkbox"/> CSF <input type="checkbox"/> Misc. Smear <input type="checkbox"/> Pericardial Fluid <input type="checkbox"/> Pleural Fluid <input type="checkbox"/> Sputum <input type="checkbox"/> Tzanck Smear (Herpes)	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> GYN Cytology <input type="checkbox"/> ThinPrep <input type="checkbox"/> ThinPrep with Imaging <input type="checkbox"/> Conventional 1 Slide Pap HPV Testing (Based on Pap results) <input type="checkbox"/> ASCUS (Ages 21-29t) <input type="checkbox"/> ASCUS, AGCUS, LGSIL, or Higher <input type="checkbox"/> HPV Regardless (Ages 30-65t) ThinPrep Vial <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Trichomonas vaginalis (TV) †(IVD) Age based testing </td> <td style="width: 33%; vertical-align: top;"> Aptima Unisex Swab (White) (Female & Male) <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Mycoplasma genitalium (MG) <input type="checkbox"/> Trichomonas vaginalis (TV) Aptima Urine Collection (Yellow) (Female & Male) <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Mycoplasma genitalium (MG) <input type="checkbox"/> Trichomonas vaginalis (TV) (Not FDA Approved) BactiSwab <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Penicillin Allergic (Reflex sensitivity if +) </td> <td style="width: 33%; vertical-align: top;"> Aptima Multitest Swab (Orange) Female ONLY <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Mycoplasma genitalium (MG) <input type="checkbox"/> Trichomonas vaginalis (TV) <input type="checkbox"/> Bacterial vaginosis* (BV) <input type="checkbox"/> Candida vaginitis/ Trichomonas vaginalis* (CV/TV) <input type="checkbox"/> Herpes simplex virus 1 & 2* (HSV) Aptima Multitest Swab (Orange) Male ONLY <input type="checkbox"/> Herpes simplex virus 1 & 2* (HSV) *Aptima Multitest Swab ONLY </td> </tr> </table>	GYN Cytology <input type="checkbox"/> ThinPrep <input type="checkbox"/> ThinPrep with Imaging <input type="checkbox"/> Conventional 1 Slide Pap HPV Testing (Based on Pap results) <input type="checkbox"/> ASCUS (Ages 21-29t) <input type="checkbox"/> ASCUS, AGCUS, LGSIL, or Higher <input type="checkbox"/> HPV Regardless (Ages 30-65t) ThinPrep Vial <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Trichomonas vaginalis (TV) †(IVD) Age based testing	Aptima Unisex Swab (White) (Female & Male) <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Mycoplasma genitalium (MG) <input type="checkbox"/> Trichomonas vaginalis (TV) Aptima Urine Collection (Yellow) (Female & Male) <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Mycoplasma genitalium (MG) <input type="checkbox"/> Trichomonas vaginalis (TV) (Not FDA Approved) BactiSwab <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Penicillin Allergic (Reflex sensitivity if +)	Aptima Multitest Swab (Orange) Female ONLY <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Mycoplasma genitalium (MG) <input type="checkbox"/> Trichomonas vaginalis (TV) <input type="checkbox"/> Bacterial vaginosis* (BV) <input type="checkbox"/> Candida vaginitis/ Trichomonas vaginalis* (CV/TV) <input type="checkbox"/> Herpes simplex virus 1 & 2* (HSV) Aptima Multitest Swab (Orange) Male ONLY <input type="checkbox"/> Herpes simplex virus 1 & 2* (HSV) *Aptima Multitest Swab ONLY
GYN Cytology <input type="checkbox"/> ThinPrep <input type="checkbox"/> ThinPrep with Imaging <input type="checkbox"/> Conventional 1 Slide Pap HPV Testing (Based on Pap results) <input type="checkbox"/> ASCUS (Ages 21-29t) <input type="checkbox"/> ASCUS, AGCUS, LGSIL, or Higher <input type="checkbox"/> HPV Regardless (Ages 30-65t) ThinPrep Vial <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Trichomonas vaginalis (TV) †(IVD) Age based testing	Aptima Unisex Swab (White) (Female & Male) <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Mycoplasma genitalium (MG) <input type="checkbox"/> Trichomonas vaginalis (TV) Aptima Urine Collection (Yellow) (Female & Male) <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Mycoplasma genitalium (MG) <input type="checkbox"/> Trichomonas vaginalis (TV) (Not FDA Approved) BactiSwab <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Penicillin Allergic (Reflex sensitivity if +)	Aptima Multitest Swab (Orange) Female ONLY <input type="checkbox"/> Chlamydia trachomatis/ Neisseria gonorrhoeae (CT/GC) <input type="checkbox"/> Mycoplasma genitalium (MG) <input type="checkbox"/> Trichomonas vaginalis (TV) <input type="checkbox"/> Bacterial vaginosis* (BV) <input type="checkbox"/> Candida vaginitis/ Trichomonas vaginalis* (CV/TV) <input type="checkbox"/> Herpes simplex virus 1 & 2* (HSV) Aptima Multitest Swab (Orange) Male ONLY <input type="checkbox"/> Herpes simplex virus 1 & 2* (HSV) *Aptima Multitest Swab ONLY		

CHECK (✓) ALL THAT APPLY

<input type="checkbox"/> Urine <input type="checkbox"/> Voided <input type="checkbox"/> Cath NON-GYN SOURCE: <input type="checkbox"/> Upper <input type="checkbox"/> Left <input type="checkbox"/> Lower <input type="checkbox"/> Right _____ _____	<input type="checkbox"/> Well woman exam <input type="checkbox"/> Previous Abnormal PAP <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> BC Pills <input type="checkbox"/> Clinically apparent infection <input type="checkbox"/> Depo Provera <input type="checkbox"/> Discharge <input type="checkbox"/> Estrogen <input type="checkbox"/> High Risk	<input type="checkbox"/> HPV Vaccinated <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Partial <input type="checkbox"/> Total <input type="checkbox"/> Irregular Menses <input type="checkbox"/> Itching/Burning <input type="checkbox"/> IUD <input type="checkbox"/> Menopausal <input type="checkbox"/> Painful sex <input type="checkbox"/> Post-partum _____ wks	<input type="checkbox"/> Pregnancy _____ wks <input type="checkbox"/> Prior ablative or excisional therapy <input type="checkbox"/> Swelling <input type="checkbox"/> Urethritis <input type="checkbox"/> Vaginitis <input type="checkbox"/> Other _____
---	---	---	--

Clinical Dx or Tx History: _____

***MEDICARE PATIENTS**

PLEASE PERSONALLY COMPLETE, SIGN, AND DATE THE MEDICARE ABN ON THE BACK OF THIS FORM

CLINICAL PATHOLOGY ASSOCIATES

1150 N. 18th St. Ste. 102 • Abilene, TX 79601 • 325-670-6500 • 1-800-478-9341

A. Notifier: CLINICAL PATHOLOGY ASSOCIATES

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. items and services** 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. items and services** below.

D. Items and services	E. Reason Medicare May not Pay:	F. Estimated Cost
Pap Test HPV Test Other special tests <ul style="list-style-type: none">• Bacterial vaginosis• Candida vaginitis/Trichomonas vaginalis• Chlamydia trachomatis/Neisseria gonorrhoeae• Herpes simplex virus 1&2• Mycoplasma genitalium• Trichomonas vaginalis	<ul style="list-style-type: none">• Frequency of testing could exceed Medicare limits.• The test may not be covered for the patient's condition.	\$35 up to \$75 (Pap Test) \$80 up to \$160 (HPV Test) \$80 up to \$120 per each Special Test

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. items and services** 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. items and services** 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. items and services** 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. items and services** 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:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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.