



Marin Medical
Laboratories

1615 HILL ROAD, SUITE C
NOVATO, CA 94947-4338

REQUESTING PHYSICIAN OR CLINIC:	CC:
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PATIENT INFORMATION (Please Print)

Date Specimen Collected	Patient Name (Last)	(First)	(MI)
Social Security Number	Date of Birth / /	Sex	Phone Number
Address		City	State Zip Code

COMPLETE BILLING INFORMATION MUST BE BELOW OR ATTACHED - PATIENT IS BILLED WHEN NOT PROVIDED!

Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Responsible Party Name / Address		
PRIMARY Insurance Name / Address	SECONDARY Insurance Name / Address		
Policy Number	Group Number	Policy Number	Group Number

CYTOLOGY

ThinPrep Pap Test HPV if ASC-US HPV Assay Chlamydia (DNA) N. gonorrhoeae (DNA)
Reflex Chlamydia included IF UNDER AGE 26

TYPE OF THINPREP PAP TEST (Check one of the following - REQUIRED)

NON-MEDICARE PATIENT:

- Routine Screening **V76.2**
- High Risk Screening **V15.89**
- Diagnostic - ICD-9 Code _____

MEDICARE PATIENT:

- Routine Screening **V76.2**
- High Risk Screening **V15.89**
- Diagnostic - ICD-9 Code _____
- Non-Covered Services **V76.2**
(Signed ABN **REQUIRED**)

MEDICARE will only pay for reasonable and necessary tests. **Medicare will only pay for a screening Pap Test every two years.** In the event the patient has more than one screening Pap in two years, **the patient is required to sign an ABN, which is on the reverse side. Medicare does not cover HPV for primary screening.**

A High Risk Pap may be ordered once every twelve months if the Pap is associated with one of the risk factors. A Diagnostic Pap must have an appropriate ICD-9 code specified. Please indicate the risk factor and ICD-9 code.

ThinPrep Pap Test **without**
Reflex Chlamydia IF UNDER AGE 26

GYN SOURCE: Endocervical Cervical Vaginal Other: _____

LMP: _____ Clinical Data / Diagnosis: _____

- Post / Perimenopausal Hysterectomy Abnormal Bleeding Oral Contraceptive IUD
- Post Partum / Nursing Hormonal RX Pregnant ____ # Weeks

NON-GYN SOURCE:

ICD-9 Code: _____

- Urine: Nipple Discharge: Rectal / Anal
- Voided Left Right Sputum
- Catheterized
- Bladder Washing Other: _____

***** LAB USE ONLY *****

NOTE: All slides and containers must be labeled with patient's full name and specimen site. Lab will reject all unlabeled specimens.

SURGICAL PATHOLOGY HISTOLOGY / FNA

Clinical Data / Diagnosis: _____

Operative Procedure: _____ FAX RESULTS TO: _____

Specimen Sites: _____

NOTE: Additional space for notes and/or drawing is available at the bottom of the reverse side of this form.

R. COHEN, MD ■ P.W. WASSERSTEIN, MD ■ F.J. KRETZSCHMAR, MD ■ C.J. JACQUES, MD ■ K.C. PRASAD, MD ■ I. CHA, MD

CYTOLOGY 415-209-6042 FAX 415-209-6053 ■ HISTOLOGY 415-209-6076 FAX 415-898-3765 ■ PATHOLOGY 415-925-7170 FAX 415-461-7228 ■ BILLING 877-239-6536

Patient Name: _____

Identification Number: _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for the checked items 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 checked items below.

Checked Items Only:	Reason Medicare May Not Pay:	Estimated Cost:
<input type="checkbox"/> Routine Screening Pap Test	Medicare only pays for this test once every (2) years.	\$ 37.94
<input type="checkbox"/> High Risk Screening Pap Test	Medicare only pays for this test once yearly.	\$ 37.94
<input type="checkbox"/> HPV Screening Test	Medicare does not pay for this test for your condition.	\$ 50.27

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 checked items 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.

OPTIONS	
Check only one box. We cannot choose a box for you.	
<input type="checkbox"/>	OPTION 1. I want the checked items 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.
<input type="checkbox"/>	OPTION 2. I want the checked items 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.
<input type="checkbox"/>	OPTION 3. I don't want the checked items listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

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.

Signature: _____	Date: _____
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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.

HIGH RISK SCREENING PAP TEST CRITERIA FOR MEDICARE COVERAGE

- A. Cervical/ Vaginal High Risk Factors:
 - i. Early onset of sexual activity (under 16 years of age)
 - ii. Multiple sexual partners (five or more in a lifetime)
 - iii. History of sexually transmitted disease (including HIV)
 - iv. Fewer than three negative Pap tests within the previous 7 years
 - v. DES exposed daughters of women who took DES during pregnancy
- B. Childbearing age women with examination indicating the presence of cervical or vaginal cancer or other abnormality during the preceding 3 years.

COVERED SERVICES FOR MEDICARE PAP TESTS

- A. Medicare will pay for Diagnostic Pap Tests for Medicare patients at any interval in the appropriate clinical setting.
- B. Medicare will pay for High Risk Screening Pap Tests for Medicare patients only once yearly.
- C. Medicare will pay for Routine Screening Pap Tests for Medicare patients only once every two years.
- D. Under all other circumstances, Pap Tests for Medicare patients are not currently a covered service by Medicare. An Advance Beneficiary Notice (ABN) must be submitted with this type of cytopathology requisition. Please explain to your patients that this is not a covered service. They will be billed separately by our offices.

HPV SCREENING FOR MEDICARE AND MEDI-CAL

- A. Medicare and Medi-Cal do not cover HPV testing for primary screening.
- B. A Medicare ABN is required for screening HPV.
- C. ASC-US reflex is covered by Medicare and Medi-Cal.