KWB PATHOLOGY ASSOCIATES
PATHOLOGY ASSOCIATES
1899 EIDER COURT - P.O. BOX 14389
TALLAHASSEE FL 32317
(850) 878-5143 (888) 878-5143

Facility Name

☐ Facility Address

Facility Phone Number

Provider Full Name

Provider NPI

GYNECOLOGICAL CYTOLOGY REQUEST

LAST NAME FIRST NAME MI

DATE OF BIRTH RACE SEX

SOCIAL SECURITY NUMBER

PATIENT ID#

☐ **STAT** ☐ **DUPLICATE REPORT TO:**

BILLING INFORMATION

PATIENT ADDRESS APT. #

CITY STATE ZIP

HOME PHONE# WORK PHONE#

BILL TO (PLEASE CIRCLE)

☐ DOCTOR ☐ PATIENT ☐ CHP ☐ MCR ☐ MCD ☐ OTHER

PRIMARY INSURANCE NAME

ADDRESS

INSURED NAME

ID # GROUP #

SPECIMEN INFORMATION

DATE TAKEN: / /

SPECIMEN SOURCE (REQUIRED)

☐ CERVIX ☐ VAGINAL ☐ ENDOCERVIX ☐ OTHER

LIQUID BASED PAP TEST OPTIONS:

☐ REFLEX TO HIGH RISK HPV TESTING IF ASCUS
☐ REFLEX TO HIGH RISK HPV TESTING IF ABNORMAL
☐ HIGH RISK HPV TESTING REGARDLESS OF PAP RESULT
☐ HIGH RISK HPV TESTING ONLY - NO PAP
ALL HIGH RISK HPV TESTING INCLUDES GENOTYPING (16/18) WHEN PERFORMED AT KWB LAB
☐ CHLAMYDIA & G.C. TESTING BY PCR

CLINICAL INFORMATION

ICD-10 CODES - REQUIRED

☐ Z12.4 CERVIX (ROUTINE CERVICAL PAP TEST)
☐ Z01.419 ROUTINE GYN EXAM
☐ Z12.72 SPECIAL SCREENING FOR MALIGNANT NEOPLASM, VAGINA
☐ Z87.42 PREVIOUS ABNORMAL PAP TEST
☐ Z87.410 HISTORY OF CERVICAL DYSPLASIA
☐ OTHER:

LMP: / /

☐ PREGNANT
☐ POST PARTUM
☐ POST MENOPAUSAL
☐ ABNORMAL BLEEDING
☐ HYSTERECTOMY
☐ HPV VACCINE
☐ HORMONE REPLACEMENT THERAPY
☐ BIRTH CONTROL PILLS
☐ DEPOPROVERA
☐ IUD
☐ BIRTH CONTROL RING
☐ RADIATION THERAPY/DATE:

LAB USE ONLY

[ ] NEGATIVE

[ ] SAT [ ] ADEQUATE T-ZONE
[ ] UNSAT [ ] INSUFF. T-ZONE

PREV:
BX:

CYTOTECH/DATE

[ ] AGREE WITH CYTOTECH

HISTORY OF ABNORMAL PAP / BX ☐ YES ☐ NO

LAST PAP TEST: DATE: PATH#:
DIAGNOSIS:

CLINICAL DIAGNOSIS:

FOR BARCODE LABEL ONLY

CAP ACCREDITED

Ketchum, Wood & Burgert Pathology Associates
1899 Eider Court, Tallahassee, FL 32308
Phone: 850-878-5143

A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (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 Test	Less than two years since last negative Pap	$50.00
CT/NG Test	Not indicated for patient's age or other criteria	$250.00
HPV Test	Not indicated for patient's age of other criteria	$250.00

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 of 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 request 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.

Physician's Name: _____

Patient's Name: _____

Accession Number: _____