Quest Diagnostics

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(415) 206-4058

Example

INFORMATION MUST BE PROVIDED OR ACCOUNT WILL BE BILLED - *Please Print Clearly*

PATIENT'S LAST NAME: Doe | FIRST NAME: Jane

SEX	DOB	PATIENT ID #/CHART #	DATE COLLECTED	TIME COLLECTED
F	1/27/07	N/A	1/27/07	12:00

PATIENT'S PHONE #	ORDERING PROVIDER	SUPERVISING PHYSICIAN
N/A	Preceptor	Salazar

ROOM/LOCATION: N/A
CC: or Clinical Comments

Med director pager
(415)443-9291

___ FAX ( ) ___

ding Medicare and Medical) that has a medical necessity requirement, you should order only those tests which are medically necessary for the diagnosis and treatment of the patient. Medicare will deny payment for a ***Screen Pap Test if the patient has had one during the last two years.***

BILL TO: ☒ OUR ACCOUNT ☐ PATIENT ☐ WC ☐ HMO/IPA
☐ MEDICARE A ☐ MEDICARE B ☐ MEDI-CAL
☐ INSURANCE ☐ CHDP ☐ FPACT

COMPLETE FOR ALL BILLING TYPES

RESPONSIBLE PARTY (Please Print)
ADDRESS
CITY/STATE/ZIP

COPY OF INSURANCE – HMO / IPA CARD REQUIRED

PRIMARY INSURANCE COMPANY – HMO/IPA HEALTH PLAN
ADDRESS (Street/City/State/Zip)
CERTIFICATE # | GROUP #
MEDI-CAL/MEDICARE # | MEDICAL ISSUE DATE REQUIRED | STATE

SEE PAGE 3 FOR ADVANCE BENEFICIARY NOTICE

ICD-9 CODE(S) OR S CODE(S) REQUIRED

STATE LAW 1050 (g) (2A) REQUIRES PATIENT NAME, COMPLETE PATIENT HISTORY AND SLIDES PROPERLY LABELED WITH PATIENT IDENTIFICATION

Medicare Limited Coverage Tests
* = May not be covered for the reported diagnosis.
F = Has prescribed frequency rules for coverage.
\+ = A test or service performed with research/experimental kit.
B = Has both diagnosis and frequency-related coverage limitations.

Did the patient sign the ABN on the back of page 3?
Is ABN attached?

ICD Diagnosis Codes (Enter All That Apply) ① ② ③ ④

GYN CYTOLOGY Test Offerings

ThinPrep®'	SurePath™'		
4100 ☐	5055 ☐	B	Liquid-Based Pap Test
4055 ☐	5060 ☐	B	Liquid-Based Pap Reflex High Risk HPV *(reflex HPV only from ASC-US interpretation)*
4075 ☐	5070 ☐	B	Liquid-Based Pap & High Risk HPV *(inc. DNAwithPap™' for age 30 and over)*

Always

Also available from the same vial with any of the PAP tests above

46830 ☐	46830 ☐	Chlamydia trachomatis DNA, SDA
46835 ☐	46835 ☐	Neisseria gonorrhoeae DNA, SDA
46840 ☐	46840 ☐	Chlamydia/N. gonorrhoeae, DNA, SDA

4010 ☐ B Conventional Pap smear, # slides ___ with Focal Point™
7381 ☐ High Risk HPV Only *(submit Digene® sampler)*
Reflex tests are performed at an additional charge.

Clinical History ***(Date of Birth, LMP, source are required)***

LMP: ___/___/___
SOURCE: 52 ☐ cervix; 53 ☐ endocervix; 51 ☐ vagina
prev. Pap ___/___/___
prev. Bx. ___/___/___
case # & result ___

022 ☐ 7 years or more since last Pap
019 ☐ Hx of LSIL or higher Pap/Bx
021 ☐ ASC/AGC Pap/Bx w/in 2 yrs
023 ☐ postmenopausal bleeding
024 ☐ postcoital bleeding
025 ☐ abnormal Gyn exam† (e.g. HPV, cervical lesion)
026 ☐ HPV Infection/Hx/Rx†
020 ☐ Gyn malignancy; Hx/Rx†
☐ other high risk factor, specify†
012 ☐ DES Exposure
028 ☐ normal exam
004 ☐ pregnant ___ wks
005 ☐ postpartum ___ wks
002 ☐ oral contraceptives
027 ☐ estrogen therapy
009 ☐ hormone therapy
011 ☐ postmenopausal
006 ☐ hysterectomy, total
007 ☐ hysterectomy w/intact cervix
010 ☐ pelvic radiation†
013 ☐ cryo/laser/Leep/cone

† explain: ___
☐ *check if biopsy was submitted on a separate requisition*

TISSUE PATHOLOGY and Non-GYN CYTOLOGY Test Offerings§

4180 ☐ **Urine** VD ☐ void CT ☐ cath
4120 ☐ **Sputum**
4190 ☐ **Anal-Rectal Cytology**
4250 ☐ **Misc.** Source ___

4940 ☐ **Breast FNA** LT ☐ left RT ☐ right SD ☐ solid CY ☐ cyst
4950 ☐ **Thyroid FNA** LT ☐ left RT ☐ right SD ☐ solid CY ☐ cyst
4930 ☐ **other FNA, source** ___

4260 ☐ **Nipple Discharge** LT ☐ left RT ☐ right
4250 ☐ **Direct Smears (Tzanck, etc), source** ___
4200 ☐ **Body Fluid, source** ___
4240 ☐ **Washing, source** ___
4240 ☐ **Brushing, source** ___

44001 ☐ **Tissue Pathology**

Procedure *(excision, cone, punch, shave, etc)*	Specific Anatomic Site	Pre-Op Dx *(duration, size, impression, etc.)*
a		
b		
c		

§ *These offerings may require special studies, markers, or stains as deemed appropriate for proper evaluation by the Quest Diagnostics Pathologist. These additional tests may result in additional charges; refer to Directory Of Services for information.*

LAB USE ONLY

Form: 95710-CTTO
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95710-23-334

SCY2