



CLIENT: ATLAS DOWNTIME

1224 N. Berkeley Ave
Peoria, IL 61603 • (309) 655-2336
1-800-533-6730 FAX (309) 624-9152

1 BILL TO INSURANCE (Bill to Patient or Patient's Insurance) If Insurance Bill is checked, please attach a copy of Insurance card.
1 CLIENT BILL (Bill to Submitter's office account) V.004

2 Patient Information - Please Print
PATIENT'S LAST NAME (PLEASE PRINT)

4 AUTHORIZING PROVIDER (FIRST & LAST NAME)

PATIENT'S FIRST NAME MI DATE OF BIRTH SEX

5 DUPLICATE REPORT TO:

ADDRESS CITY STATE ZIP

6 COLLECTOR'S INITIALS 7 COLLECTED DATE 8 COLLECTED/PLACED IN FIXATIVE AM PM

PHONE NUMBER SOCIAL SECURITY NUMBER

9 ICD Diagnosis Code: All requests must be accompanied by a valid alpha-numeric diagnosis code as to establish medical necessity for tests ordered. If the ICD code is not provided and/or does not meet coverage requirements, this can result in test delays and/or reimbursement delays.

3 Advanced Beneficiary Notice Attached: YES NO

You MUST issue an ABN when there is any possibility to expect that Medicare may deny payment if the test is not deemed reasonable and necessary under Medicare Program standards. If you believe that a test subject to a frequency limitation exceeds the Medicare Program frequency limits for test ordering, you MUST issue an ABN before you collect and order the test. With this requirement, you must evaluate test frequency limits and look up how many times the test was ordered during the specific timeframe for that patient. Failure to submit an ABN to OSF in these cases, resulting in claim denial, will result in a service charge to your office.

1) 2) 3) 4)

REQUISITION NUMBER: OSF USE ONLY

OSF USE ONLY PLACE EPIC PAP STICKER HERE

OSF USE ONLY PLACE EPIC HPV STICKER HERE

OSF USE ONLY PLACE EPIC GC/CHLAMYDIA STICKER HERE

10 GYNECOLOGIC CYTOLOGY* - PAP Vaginal Cervical Endocervical SCREENING or DIAGNOSTIC

Pap APPAP LAB1768 Reflex High Risk HPV, if ASCUS Pap (HPV will ONLY be performed when Pap diagnosis is ASCUS) OR HPV HPVIRS LAB1192 (Cotest performed regardless of Pap diagnosis)

11 GYNECOLOGICAL HISTORY

Menstrual History: Date of LMP: Post Menopausal Post Partum Pregnant Abnormal Bleeding Other

Prior or Present Therapy: Hormone Chemotherapy Hysterectomy Cone Resection Radiotherapy Other

Previous Pap/Biopsy Results: Negative ASCUS / AGUS Low Grade Dysplasia High Grade Dysplasia Malignant (Site and Type)

12 NON-GYNECOLOGIC CYTOLOGY LAB1769 SITE: OSF LAB USE: Is this a shared specimen? Y or N

Voided Urine Catheterized Urine Bladder Washing Fluid Scraping/Discharge Fine Needle Aspiration Other OSF USE: Volume Consistency Color

Clinical History / Impression:

ADDITIONAL COMMENTS:

13 SURGICAL PATHOLOGY LAB1770 Specimen(s), Sources & Procedures: Give the duration and description of lesion and type of biopsy, such as shave, needle, etc.

Table with 3 columns: Site (Laterality) and Source (Origin), Procedure (how sample was obtained), Preop/Postop Diagnosis Codes. Rows 1), 2), 3)

*An ABN must be issued and signed by the patient if you believe Medicare will not pay for an item or service, especially if medical necessity requirements are not met. See CMS NCD 210.2 for Pap Screening medical necessity and frequency determinations. See CMS NCD 190.2 for Pap Diagnostic medical necessity criteria.