



CLIENT: ID:

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

BILL TO INSURANCE (Bill to Patient or Patient's Insurance) If Insurance Bill is checked, please attach a copy of Insurance card.
CLIENT BILL (Bill to Submitter's office account) V.005

2 Patient Information - Please Print
PATIENT'S LAST NAME (PLEASE PRINT)
PATIENT'S FIRST NAME MI DATE OF BIRTH SEX
ADDRESS CITY STATE ZIP
PHONE NUMBER SOCIAL SECURITY NUMBER

4 AUTHORIZING PROVIDER (FIRST & LAST NAME)
5 DUPLICATE REPORT TO:

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.

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

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.

REQUISITION NUMBER: OSF USE ONLY

1) 2) 3) 4)

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.
Site (Laterality) and Source (Origin) Procedure (how sample was obtained) Preop/Postop Diagnosis Codes
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.