CUMC-Bergan Mercy Laboratory
7500 Mercy Rd
Omaha, NE 68124
Phone: (402) 717-5227
Fax: (402) 717-5252

Client Code:
Clinic:
Address:
Address Line2
PHONE:
FAX:

LAB USE ONLY
Date Received:
Number of Slides:
Accession Number:
Accession Number:
Account Number:
SMS Admit Number:

PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION REQUIRED FOR ALL TESTING

(Legal Name) Last	First	MI	DOB	SSN	☐ Male ☐ Female	Phone Number

Patient ID	Physician #1 First & Last Name	Physician #2 First & Last Name	Date Collected	Time Collected

REQUIRED: Indicate Appropriate ICD10 Numeric Code(s) in Box(es) Below

ICD10	1.	2.	3.

CHECK ONE:
☐ **Bill to Office Account**
☐ **Bill to Patient / Insurance**
(MUST complete information below or attach registration sheet for ALL patients.)

MEDIPASS AUTHORIZATION NUMBER

____

Numeric code must be given for all PAP testing to be billed to the patient or patient's insurance. If information is not complete, the form and specimen will be returned for completion prior to testing.

☐ **SCREENING PAP TEST**
No signs or symptoms of disease. Strictly preventive in nature.
Medicare Patients: See waiver section below and sign as appropriate.

☐ **DIAGNOSTIC PAP TEST**
There are (or have been) signs or symptoms of disease. Appropriate ICD10 numeric code is written above.

Guarantor / Responsible Party	**Primary Insurance**	**Secondary Insurance Name**
Phone Number of Guarantor	Policy Number	Policy Number
Address	Group Number	Group Number
City, State, Zip	Address of Payer	Address of Payer

GYN (PAP) CYTOLOGY

SOURCE OF SPECIMEN
☐ Cervical / Endocervical
☐ Vaginal

SPECIMEN SUBMITTED
☐ Smeared Slide
(Label slide with patient name and DOB in pencil.)
☐ Liquid-Based PAP Test
(Label container with patient name and DOB.)

Clinical Data: LMP: Date: ______

☐ Biopsy also sent
☐ B.C. Pill
☐ I.U.D.
☐ Pregnant
☐ Post-Partum
☐ Breast Feeding
☐ Menopause
☐ Hysterectomy
☐ Hormone Rx.
☐ Abnormal bleeding
☐ Colpo
☐ Laser
☐ Cryo
☐ Cone / Leep / Leitz
☐ Chemo
☐ Radiation
☐ Other
____

Previous PAP: Date: ______________ Result: ________________________

Dr. Comments:
☐ HPV ☐ Chlamydia ☐ GC

NON-GYN CYTOLOGY / FLUID

SOURCE OF SPECIMEN
☐ Sputum
☐ Bronch-Wash __________
☐ Bronch-Brush __________
☐ Bal __________
☐ Fine Needle Aspiration
Organ Site: __________
____
☐ Other Specimen: ________
____
____
☐ Gastric
☐ Esophageal
☐ Breast Fluid R or L
☐ CSF
☐ Urine
☐ Ovarian Fluid R or L
☐ Pleural Fluid R or L
☐ Perit Fluid
☐ Cul-De-Sac Fluid
☐ Pericard Fluid

Clinical History:

HISTOLOGY / TISSUE

TISSUE SPECIMEN AND SITE: LIST ALL
☐ Single Biopsy / Source: ____________________
☐ Biopsy / Multiple (State Source Each Specimen Below)

A. ____
B. ____
C. ____
D. ____
E. ____

Pre-Op Diagnosis

History (Pertinent Clinical History)

Post-Op Diagnosis:

Formalin Added Time

When asterisked tests are ordered on Medicare patients they are likely to be denied by Medicare unless medical necessity is established.
Consult reference guide and have patient sign waiver, if appropriate.
*Medicare limited coverage test. Medicare may not pay for this service or this many services for my condition.
**Medicare may not pay for test labeled "RESEARCH" or "INVESTIGATIONAL USE ONLY."

ABN waiver signed and attached: ☐ **Yes** ☐ **No**