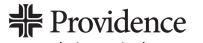
DID YOU INCLUDE...

- DIAGNOSIS CODE(S)?
- TEST(S) TO BE PERFORMED?
- PROVIDER FIRST/ LAST NAME?
- WHO TO BILL?

CYTOLOGY OUTPATIENT REQUEST FORM



Alaska Medical Center

P.O. Box 196604 Anchorage, AK 99519-6604

ORDERING PROVIDER SIGNATURE:

CYTOLOGY (907) 212-3098 FAX (907) 212-4873

	OIGHATOTIE					
PLEASE PRINT CLEARLY ALL INFORMA PATIENT'S FULL LEGAL NAME (REQUIRED)	MATION MUST BE PROVIDED. USE BLACK OR BLUE INK ONLY FIRST: MI:		□STAT			
	inot.		".	Phone:		
LAST:				Fax #:		
DATE OF BIRTH (REQUIRED): SEX (REQUIRED):				Fax Results Immediately		
MALE		☐ FEMALE ☐ OTHER				
DIAGNOSIS ICD CODE(S) (REQUIRED):		ADDITIONAL COPIES TO	:			
☐ CLIENT/PHYSICIAN ACCOUNT ☐ PATIENT BILL ☐ INSURANCE			ST, MIDDLE)		DATE OF BIRTH	
BILL: #: COMPLETE REQUIRED COMPLETE COMPLETE REQUIRED AREAS & AREAS BELOW ALL AREAS						
GUARANTOR (LAST, FIRST, MIDDLE) (REQUIRED EXCEPT FOR MEDICARE) DATE OF BIRTH		ADDRESS (CITY, STATE, ZIP)				
ADDRESS	PHONE #		PATIENT RELAT	ATIENT RELATIONSHIP		
CITY/STATE/ZIP CODE:	INSURANCE CO.					
PT. RELATIONSHIP:	CLAIMS ADDRESS (CITY	. STATE. ZIP)				
	525 .125.1255 (6171, 517112, 211)					
HOME PHONE NO.: WORK PHONE NO.:		INSURANCE PHONE INSURANCE/MEM		MBER POLICY # GROUP #		
TODAY'S DATE (REQUIRED):	DLLECTION DATE (REQUIRED)	:	COLLECTIO	N TIME (REQUIRED):		
GYNECOLOGIC CYTOLOGY		NON-GYNECOLOGIC	CYTOLOGY	CLINICAL HIS	STORY	
SOURCE: HPV testing includes screening for Genotype 16, 18 &		☐ SPUTUM ☐ BRONCH. WASH: Lobe ☐ LEFT ☐ RIGHT ☐ BRONCH. BRUSH: Lobe ☐ LEFT ☐ RIGHT				
□ CERVICAL □ VAGINAL □ PAPHP (LAB13438) - Pap+HPV (regardless) □ ENDOCERVICAL □ PAPACR (LAB13436) - Pap+Reflex to HPV if ASCUS				-		
				_		
☐ PSHPV (LAB1793) Misc. HPV Primary Screen reflex		☐ BAL Indicate Lobe		_		
enter test comment PAML test code PSHPV		□ PLEURAL (CHEST) FLUID				
☐ SLIDES (Please indicate # of slides)		☐ LEFT ☐ RIGHT ☐ ASCITES (ABDOMINAL) FLUID				
☐ GC/CHL by PCR (LAB1376) - Using Liquid Based Pap		☐ URINE (FRESH ONL)	*			
One of the Fallentine Mark Be Observed	■ BREAST NIPPLE SE					
One of the Following <u>Must</u> Be Checked	☐ LEFT ☐ F					
☐ Screening PAP	□ CSF					
☐ Diagnostic PAP	☐ OTHER	CF.				
(FOR MEDICARE SEE NOTICE ON REVERSE)		FINE NEEDLE ASPIRAT				
GYN HISTORY		☐ BREAST ☐ LEFT ☐ RIGHT ☐ THYROID ☐ LEFT ☐ RIGHT ☐ LYMPH NODE SITE				
MP MM/DD/YY (REQUIRED)						
	DES Exposure	OTHER_				
	•					
·	Radiation	MISCELLANEOUS				
	Chemotherapy	☐ PNEUMOCYSTIS ST (MICROBIOLOGY)	PNEUMOCYSTIS STAIN			
☐ Post Partum wks ☐ History of Malignancy ☐	Gyn Biopsy	URINE HEMOSIDERIN				
☐ Post Abortion ☐ Hysterectomy (total) ☐	☐ RECURRENT ASPIRATION PANEL (LIPID)		LAB USE ON	LAB USE ONLY:		
☐ Post Menopausal ☐ Hysterectomy (cervix intact) ☐			ACCESSION N	ACCESSION NUMBER:		
ABNORMAL PAP HISTORY: (INCLUDE DATES)			MEDICAL REC	MEDICAL RECORD #:		
	□ OTHER		ACCOUNT NU	ACCOUNT NUMBER:		

MEDICARE PAP SMEAR NOTICE

Please Note: According to Medicare B guidelines, a screening pap smear can only be performed and reimbursed on beneficiaries once in a two year period; or whose attending physicians believe more frequent tests are necessary due to evidence that there are high risks of developing cervical cancer. Diagnosis codes must substantiate the above, or the beneficiary will be responsible for the balance in full. An Advance Beneficiary Notice must be signed if the beneficiary's testing exceeds Medicare's frequency limitations for Pap smear testing or if the diagnosis does not support a diagnostic Pap smear.

NOW OFFERING MORE SPECIMEN COLLECTION LOCATIONS TO SERVE YOU BETTER

Providence Health Park

3841 Piper Street, Suite T-211 Anchorage, AK 99508 Phone (907) 212-5815 Fax (907) 212-3632 **Tudor Square**

3425 E. Tudor Road Anchorage, AK 99504 Phone (907) 644-8252 Fax (907) 212-3632

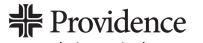
Southside Anchorage

345 W 104th, Suite 300 Anchorage, AK 99515 Phone (907) 212-7413 Fax (907) 212-3632

DID YOU INCLUDE...

- DIAGNOSIS CODE(S)?
- TEST(S) TO BE PERFORMED?
- PROVIDER FIRST/ LAST NAME?
- WHO TO BILL?

CYTOLOGY OUTPATIENT REQUEST FORM



Alaska Medical Center

P.O. Box 196604 Anchorage, AK 99519-6604

ORDERING PROVIDER SIGNATURE:

CYTOLOGY (907) 212-3098 FAX (907) 212-4873

	OIGHATOTIE					
PLEASE PRINT CLEARLY ALL INFORMA PATIENT'S FULL LEGAL NAME (REQUIRED)	MATION MUST BE PROVIDED. USE BLACK OR BLUE INK ONLY FIRST: MI:		□STAT			
	inot.		".	Phone:		
LAST:				Fax #:		
DATE OF BIRTH (REQUIRED): SEX (REQUIRED):				Fax Results Immediately		
MALE		☐ FEMALE ☐ OTHER				
DIAGNOSIS ICD CODE(S) (REQUIRED):		ADDITIONAL COPIES TO	:			
☐ CLIENT/PHYSICIAN ACCOUNT ☐ PATIENT BILL ☐ INSURANCE			ST, MIDDLE)		DATE OF BIRTH	
BILL: #: COMPLETE REQUIRED COMPLETE COMPLETE REQUIRED AREAS & AREAS BELOW ALL AREAS						
GUARANTOR (LAST, FIRST, MIDDLE) (REQUIRED EXCEPT FOR MEDICARE) DATE OF BIRTH		ADDRESS (CITY, STATE, ZIP)				
ADDRESS	PHONE #		PATIENT RELAT	ATIENT RELATIONSHIP		
CITY/STATE/ZIP CODE:	INSURANCE CO.					
PT. RELATIONSHIP:	CLAIMS ADDRESS (CITY	. STATE. ZIP)				
	525 .125.1255 (6171, 517112, 211)					
HOME PHONE NO.: WORK PHONE NO.:		INSURANCE PHONE INSURANCE/MEM		MBER POLICY # GROUP #		
TODAY'S DATE (REQUIRED):	DLLECTION DATE (REQUIRED)	:	COLLECTIO	N TIME (REQUIRED):		
GYNECOLOGIC CYTOLOGY		NON-GYNECOLOGIC	CYTOLOGY	CLINICAL HIS	STORY	
SOURCE: HPV testing includes screening for Genotype 16, 18 &		☐ SPUTUM ☐ BRONCH. WASH: Lobe ☐ LEFT ☐ RIGHT ☐ BRONCH. BRUSH: Lobe ☐ LEFT ☐ RIGHT				
□ CERVICAL □ VAGINAL □ PAPHP (LAB13438) - Pap+HPV (regardless) □ ENDOCERVICAL □ PAPACR (LAB13436) - Pap+Reflex to HPV if ASCUS				-		
				_		
☐ PSHPV (LAB1793) Misc. HPV Primary Screen reflex		☐ BAL Indicate Lobe		_		
enter test comment PAML test code PSHPV		□ PLEURAL (CHEST) FLUID				
☐ SLIDES (Please indicate # of slides)		☐ LEFT ☐ RIGHT ☐ ASCITES (ABDOMINAL) FLUID				
☐ GC/CHL by PCR (LAB1376) - Using Liquid Based Pap		☐ URINE (FRESH ONL)	*			
One of the Fallentine Mark Be Observed	■ BREAST NIPPLE SE					
One of the Following <u>Must</u> Be Checked	☐ LEFT ☐ F					
☐ Screening PAP	□ CSF					
☐ Diagnostic PAP	☐ OTHER	CF.				
(FOR MEDICARE SEE NOTICE ON REVERSE)		FINE NEEDLE ASPIRAT				
GYN HISTORY		☐ BREAST ☐ LEFT ☐ RIGHT ☐ THYROID ☐ LEFT ☐ RIGHT ☐ LYMPH NODE SITE				
MP MM/DD/YY (REQUIRED)						
	DES Exposure	OTHER_				
	•					
·	Radiation	MISCELLANEOUS				
	Chemotherapy	☐ PNEUMOCYSTIS ST (MICROBIOLOGY)	PNEUMOCYSTIS STAIN			
☐ Post Partum wks ☐ History of Malignancy ☐	Gyn Biopsy	URINE HEMOSIDERIN				
☐ Post Abortion ☐ Hysterectomy (total) ☐	☐ RECURRENT ASPIRATION PANEL (LIPID)		LAB USE ON	LAB USE ONLY:		
☐ Post Menopausal ☐ Hysterectomy (cervix intact) ☐			ACCESSION N	ACCESSION NUMBER:		
ABNORMAL PAP HISTORY: (INCLUDE DATES)			MEDICAL REC	MEDICAL RECORD #:		
	□ OTHER		ACCOUNT NU	ACCOUNT NUMBER:		

MEDICARE PAP SMEAR NOTICE

Please Note: According to Medicare B guidelines, a screening pap smear can only be performed and reimbursed on beneficiaries once in a two year period; or whose attending physicians believe more frequent tests are necessary due to evidence that there are high risks of developing cervical cancer. Diagnosis codes must substantiate the above, or the beneficiary will be responsible for the balance in full. An Advance Beneficiary Notice must be signed if the beneficiary's testing exceeds Medicare's frequency limitations for Pap smear testing or if the diagnosis does not support a diagnostic Pap smear.

NOW OFFERING MORE SPECIMEN COLLECTION LOCATIONS TO SERVE YOU BETTER

Providence Health Park

3841 Piper Street, Suite T-211 Anchorage, AK 99508 Phone (907) 212-5815 Fax (907) 212-3632 **Tudor Square**

3425 E. Tudor Road Anchorage, AK 99504 Phone (907) 644-8252 Fax (907) 212-3632

Southside Anchorage

345 W 104th, Suite 300 Anchorage, AK 99515 Phone (907) 212-7413 Fax (907) 212-3632