

1355 RIVER BEND DRIVE DALLAS, TX 75247 P 214.638.2000 P 800.258.1253 F 214.237.1731 www.ProPath.com

Patient Information: Name, Address, City, State, Zip code, Phone, Birth date, Sex, Social security number, Patient ID number.

Billing Information: Bill to, Insurance company name, Employer name, Name of insured, Policy / member ID #, Group #, Mail claim to, Address, City, State, Zip code.

PHYSICIAN ACKNOWLEDGEMENT (Required) Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient. Medicare Patients: The Advance Beneficiary Notice, if required, must be completed, signed by the patient and attached. Physician's Signature: Date Ordered:

Date Collection date and time: M: D: Y: Time:

Provider Information: Send duplicate report to: Name, Address, City/State/Zip: Check appropriate box above to indicate ordering provider. Referring provider: NPI#: City/State/Zip:

Diagnosis Codes: Diagnosis code(s): Required for each test ordered. 1) 2) 3)

Clinical history: Routine exam, High-risk exam, Pregnant, Postpartum, Postmenopausal, LMP (date), Previous Pap, HPV positive, Hysterectomy (total), Hysterectomy (partial), Colposcopic findings / impress / other information: IUD, OCP/Hormone Rx, History of malignancy (specify below)

GYN cytology / HPV testing: Source: Cervix, Endocervix, Vagina, Other (specify): Standing order for Pap / molecular testing, Age-based cervical cancer screening, Age-based cervical cancer abd STI screening

Customized testing: Pap only, High-risk HPV only, Reflex HPV genotyping, Pap with high-risk HPV, Reflex HPV genotyping, Pap with reflex high-risk HPV, If ASC-US, If ASC-US or LSIL, Add reflex HPV genotyping

Molecular testing: Panel testing (ProPathSwab or ThinPrep vial): Vaginitis, Leukorrhea, STI Screening, Infertility, Reflex Candida speciation if Candida positive

Individual testing (ProPathSwab or ThinPrep vial unless indicated): Candida species, Reflex Candida speciation, Chlamydia trachomatis, Gardnerella vaginalis, Group B Streptococcus, Penicillin- allergic, HSV 1 / 2 by PCR, 24325 - Mycoplasma genitalium, Neisseria gonorrhoeae, Trichomonas vaginalis

Tissue pathology: Source: A) B) C) D)

Non-gynecologic cytology: Urine cytology: Voided, Catheterized, Bladder washing, Other cytology: Anal cytology, Nipple discharge, Fine needle aspiration, Other (specify):

Aptima Urine Specimen Transport Kit CT/NG TV M.gen. V67, 03/23

Please include the diagnosis code(s) at the highest level of specificity as documented in the patient medical record for this requisition date of service.

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D. Laboratory Tests	E. Reason Medicare May Not Pay:	F. Estimated Cost
____ (1) Pap Test	____ Medicare does not pay for this test	____ \$75 - \$85
____ (2) HPV Test	____ Not covered for patient's condition	____ \$150
____ (1) Vaginosis Panel (APTIMA® swab)	____ Not covered for patient's condition	____ \$294

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any question that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 06/30/2023)

Form Approved OMB No. 0938-0566

The ABN is located on the back of the first copy of this requisition.

Please complete the appropriate information and ask the patient to sign the back of the first copy.

We appreciate your help.