AnMed

PATHOLOGY REQUEST

Laboratory Services

800 North Fant St., Anderson SC 29621

864.512.1816 / 1.800.868.5877

PPA PIEDMONT PATHOLOGY ASSOCIATES

☐ Bill Patient Insurance ☐ Bill Medicare/Medicaid ☐ Bill Client Account

Patient Name (Last) (First) (MI)	This section must be completed for Patient or Third-Party Billing
	Insured's Name
Address City State Zip Code	Street Address or PO Box
Sex / Age / Date of Birth / Patient Phone No.	City State Zip Code
Office Chart No. / Social Security No.	Medicare No. / Medicaid No.
Ordering Provider / Order Date	Insurance Company Name
Diagnosis	Claims Address / ID #
Collection Date / Date Sent	Group #
Medicare will only pay for tests that meet Medicare local coverage criteria and are reasonable and necessary to treat or diagnose an individual patient.	Insured's Employer Name
I hereby authorize the release of medical information related to the service described hereon and I understand that I am responsible for payment in full for any balance not covered by my health insurance. Patient Signature _____ Date _____	Clinical Data or Other Information

Gynecologic (PAP Testing)

Test Ordered:

☐ ThinPrep – HPV regardless
☐ ThinPrep – HPV regardless with reflex to HPV 16, 18/45 if positive
☐ ThinPrep – HPV if ASCUS
☐ ThinPrep – HPV if ASCUS with reflex to HPV 16, 18/45 if positive
☐ ThinPrep Only

Additional Test: ☐ GC, Chl ☐ GC, Chl, Trich ☐ Trich

Source: ☐ Cervix ☐ Endocervix ☐ Vagina

Appropriate Box must be Checked

☐ Diagnostic PAP test ICD10_____
☐ Non-Medicare Routine Screening PAP ICD10_____
☐ Medicare Routine Low Risk Screening PAP ICD10_____
☐ Medicare High Risk Screening PAP ICD10_____

Medicare will deny payment for a screening PAP smear if one has been done during the last two years. Medical necessity must be determined for all diagnostic PAP smears. Complete and attach ABN if necessary.

Clinical Information/History

LMP: _____

☐ Pregnant ☐ Postpartum ☐ Postmenopausal
☐ Hysterectomy ☐ Discharge ☐ Lesion or Mass
☐ IUD ☐ Radiation Rx ☐ Colpo Abnormality
☐ Chemotherapy ☐ DES Exposure ☐ Amenorrhea/Infertility
☐ Abnormal Bleeding/Spotting ☐ Hormone: _____Type
☐ Previous Abnormal PAP ☐ Previous Abnormal Biopsy
☐ Other: _____

Cytology Studies

Fine Needle Aspiration

☐ Thyroid R _____ L _____
☐ Lung R _____ L _____
☐ Lymph Node R _____ L _____
☐ Liver R _____ L _____
☐ Breast Mass R _____ L _____
☐ Other: _____

Non-Gynecological

☐ Urine Voided
☐ Urine Catheterized
☐ Bladder Washing
☐ Bronchial Washing R _____ L _____
☐ Bronchial Brushing R _____ L _____
☐ Fluid-Source: _____

Tissue Source for Histopathology (Please list separately)

A. _____
B. _____
C. _____
D. _____

Time tissue removed from the body: _____

Time tissue placed in Formalin: _____

White Copy – AnMed Yellow Copy – Client REV. 5/24