Northwell Health® Labs

ANATOMIC PATHOLOGY

450 Lakeville Rd., Suite M50, Lake Success, NY 11042
(516) 719-1000 • 1-800-472-5757

OUTLINED AREAS MUST BE COMPLETED

PATIENT

PATIENT IDENTIFIER			
NAME, LAST (Please Print)	FIRST	M.I.	
BIRTHDATE	M/F	DATE/TIME COLLECTED	
STREET	PHONE #		
CITY	STATE	ZIP	

BILLING

INSURANCE CARRIER NAME	ADDRESS	
INSURED NAME	INSURED ID#	PT. RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Dependent
GROUP # or NAME		☐ INSURANCE CHANGE
☐ MEDICARE #	☐ MEDICAID #	☐ SELF-PAY

AFFIX TO SPECIMEN CONTAINER

I attest that this patient has been informed about and has given consent for the test(s) I have ordered below under applicable law.

X _____
PHYSICIAN SIGNATURE

DIAGNOSIS CODES (MUST BE PROVIDED)	

***SEE REVERSE SIDE OF THIS PAGE FOR THE "ADVANCED BENEFICIARY NOTIFICATION":**
Medicare Patient Must Be Counseled on Medicare Medical Necessity Policy.

CYTOLOGY - Complete all information requested

TYPE OF PAP SPECIMEN:

LMP: | DATE OF LAST PAP:

Source: ☐ Cervical ☐ Vaginal ☐ Endocervical
☐ ThinPrep and HPV (High Risk)
☐ ThinPrep and HPVGENO (includes16,18/45)
☐ ThinPrep w/Reflex upon ASCUS (High Risk HPV only)
☐ ThinPrep w/Reflex upon ASCUS (HPVGENO16,18/45)
☐ ThinPrep only ☐ Pap Smear (conventional)
☐ 241 HPV screen (High Risk only) without Pap test
☐ 251 HPVGENO (HPV High Risk w/Reflex to16,18/45 only) without Pap test
☐ 154 Chlamydia/GC by Aptima (CTNGAMP)
☐ 250 Chlamydia/GC by Thin Prep (CTNGTP)
☐ 240 Trichomonas ☐ Aptima ☐ ThinPrep (TRICHAMP)

CLINICAL HISTORY: (check all that apply)

☐ ROUTINE EXAM
☐ ORAL CONTRACEPTIVES
☐ POST MENOPAUSAL
☐ ESTROGEN
☐ *ABNORMAL BLEEDING
☐ *HISTORY OF MALIGNANCY
☐ *HYSTERECTOMY (TOTAL)
☐ *HYSTERECTOMY (CERVIX INTACT)
☐ HORMONE THERAPY
☐ OTHER _____

NON-GYNECOLOGIC

RESPIRATORY ☐ CL FL CYTO
☐ SPUTUM
☐ BRONCH-WASH L R
☐ BRONCH-BRUSH L R
☐ BRONCH-LAVAGE L R
☐ OTHER _____

☐ **GI TRACT** _____
☐ **CSF**
☐ **BODY CAVITY FLUID** _____
☐ NIPPLE DISCHARGE L R
☐ OVARIAN CYST L R
☐ OTHER _____

URINARY
☐ VOIDED
☐ CATHETERIZED ☐ OTHER _____

FINE NEEDLE ASPIRATION

☐ BREAST ☐ THYROID ☐ OTHER
☐ LYMPH NODE ☐ SALIVARY GLAND ☐ # PASSES _____

INDICATE ☐ L or ☐ R SITE/SPECIFY _____

THYROID MOLECULAR: ☐ THYROSEQ ☐ AFIRMA ☐ QUEST
REFLEX: ☐ 1st AUS ☐ 2nd AUS ☐ SUSN

PREVIOUS TISSUE EXAM: _____
☐ CYSTIC ☐ SOLID

CLINICAL HISTORY AND DIAGNOSIS: _____

FLOW CYTOMETRY SPECIMEN SUBMITTED:

Orderable: TMWG ☐ YES ☐ NO

BIOPSY / SLIDE CONSULT

☐ BIOPSY ☐ BONE MARROW ☐ SLIDE CONSULT

DATE/TIME COLLECTED: _____

FOR BREAST: Time Removed from body: _____
Time Placed in Formalin: _____

CLINICAL HISTORY:

SURGICAL PROCEDURE

RETURN CONSULT SLIDES TO:

ATTN: _____

SITE OF SPECIMEN:

1. _____	7. _____
2. _____	8. _____
3. _____	9. _____
4. _____	10. _____
5. _____	11. _____
6. _____	12. _____

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I authorize the release of any medical information necessary to process this claim and request that payment of benefits be made to: **NORTHWELL HEALTH LABORATORIES.**

Signed: _____ Date: _____ If other than patient signature, reason patient cannot sign/Identification. Explain: _____

Northwell Health® Labs

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.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions 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:

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