LabGenomics

NON-GYN CYTOLOGY REQUISITION

CLIA ID# 31D2026917

PATIENT INFORMATION *(REQUIRED)*

Date of Collection: _____ Time of Collection: _____

Cell #: _____ Email: _____

Home #: _____ Street Address: _____

Apt: _____ City: _____ State: _____ Zip: _____

DOB (MM/DD/YYYY): _____ / _____ / _____ SSN #: _____

(SSN # required for uninsured patients only)

Gender Identity and Sexual Orientation

- ☐ Male
- ☐ Female
- ☐ Non-Binary/Genderqueer
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Lesbian, Gay or Homosexual
- ☐ Bisexual
- ☐ Other: _____

Race and Ethnicity — Select all that apply

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Choose not to disclose
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Other: _____

Guidelines for patient demographics are provided by NJDOH/CLIS (NJSA 45:9-42.46 to -42.49)

REFERRING PHYSICIAN INFORMATION *(REQUIRED)*

INSURANCE INFORMATION *(REQUIRED)*

Policyholder Name: _____

Insurance Name: _____

Policy #: _____

Group #: _____

Please provide a copy of the front & back of insurance card(s).

- ☐ Bill Insurance
- ☐ Bill Client
- ☐ Self Pay

SPECIMEN ID:

T128353

LAB ACCESSION #:

_____

CLINICAL HISTORY

_____

_____

_____

ICD-10 CODES:

_____

_____

NON-GYN CYTOLOGY/FLUIDS AND BRUSHINGS

- ☐ **URINE:** ☐ Voided ☐ Cysto. ☐ Cath ☐ Other: _____
- ☐ **GASTRIC BRUSH** ☐ **ESOPHAGEAL BRUSH** ☐ **COLONIC BRUSH**
- ☐ **BODILY FLUID:** ☐ Abdominal ☐ Pleural ☐ Joint: _____
- ☐ **SPUTUM** ☐ **CUTANEOUS LESIONS (VIRAL/TZANCK SMEAR)**
- ☐ **OTHER:** _____

ASPIRATION CYTOLOGY

- ☐ **BREAST (#1):** ☐ Right ☐ Left ☐ Cyst ☐ Mass/Lump (____o'clock)
- ☐ **BREAST (#2):** ☐ Right ☐ Left ☐ Cyst ☐ Mass/Lump (____o'clock)
- ☐ **NECK MASS:** ☐ Right ☐ Left ☐ **LYMPH NODE:** _____
- ☐ **SALIVARY GLAND:** _____ ☐ **OTHER:** _____

THYROID FINE NEEDLE ASPIRATION CYTOLOGY

THYROID (#1 SITE): ☐ Right Lobe ☐ Left Lobe ☐ Isthmus ☐ Upper Pole ☐ Mid Lobe ☐ Lower Pole

THYROID (#2 SITE): ☐ Right Lobe ☐ Left Lobe ☐ Isthmus ☐ Upper Pole ☐ Mid Lobe ☐ Lower Pole

SPECIMEN #1 DESCRIPTION

VOLUME: ☐ Scant ☐ Less than 1 cc. ☐ _____ cc

COLOR: ☐ Bloody/Red ☐ Amber ☐ Yellow ☐ Other: _____

CLARITY: ☐ Clear ☐ Opaque ☐ Cloudy ☐ Other: _____

NUMBER OF PASSES: ☐ One ☐ Two ☐ Three ☐ Other: _____

SLIDES: # Air dried _____ # Fixed _____ # Vial(s)/Containers) _____

SPECIMEN #2 DESCRIPTION

VOLUME: ☐ Scant ☐ Less than 1 cc. ☐ _____ cc

COLOR: ☐ Bloody/Red ☐ Amber ☐ Yellow ☐ Other: _____

CLARITY: ☐ Clear ☐ Opaque ☐ Cloudy ☐ Other: _____

NUMBER OF PASSES: ☐ One ☐ Two ☐ Three ☐ Other: _____

SLIDES: # Air dried _____ # Fixed _____ # Vial(s)/Containers) _____

Please submit copies of reports for Scan, Sonography, previous aspiration(s) and laboratory results. Comments: _____

_____

BOTH PATIENT AND PHYSICIAN MUST SIGN TO APPROVE TESTING

By signing below, I confirm I have read the ABN on the reverse side.

Patient Signature: _____

I authorize the release of medical information related to services provided herein to my health plan/ insurance carrier and authorize payment directly to LabGenomics and/or lab services provider. I assume responsibility for payment of charges not covered by my healthcare insurer.

Physician Signature: _____

CMS requires physician signature on all requisitions. LabGenomics is responsible for verifying signature prior to performing testing.

300 Columbus Circle, Suite A, Edison, NJ 08837 | Tel: (866) 909-PATH | Fax: (908) 272-1478 | www.labgusa.com

T128353 **A** Site _____ Name _____

T128353 **B** Site _____ Name _____

T128353 **C** Site _____ Name _____

T128353 **D** Site _____ Name _____

T128353 **E** Site _____ Name _____

T128353 **F** Site _____ Name _____

T128353 **G** Site _____ Name _____

T128353 **H** Site _____ Name _____

T128353 **I** Site _____ Name _____

T128353 **J** Site _____ Name _____

Notifier(s):

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box 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 items listed or checked in the box below.

Laboratory Tests	Reason Medicare May Not Pay	Estimated Costs

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 checked items listed in the first box 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.

☐ **OPTION 1**: I want the Laboratory Test(s) 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 Laboratory Test(s) 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 do not want the Laboratory Test(s) listed above, I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

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.

Signature:	Date: