AMARILLO PATHOLOGY ASSOCIATES

PO Box 51525 Amarillo, TX 79159-1525 • Phone: 806-354-1754 • Phone: 806-212-5942 • Billing: 806-355-7286

APA ACCESSION NUMBER

SUBMITTING PHYSICIAN SIGNATURE: _____ **COLLECTION DATE**: _____

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

_____

PHONE: _____ SEX: M _____ F _____

DOB: _____ SS#: _____

RESPONSIBLE PARTY: _____

BILL: PATIENT _____ INS _____ DR GROUP _____

PATIENT INSURANCE: ATTACH COPY OF CARD OR COMPLETE INFORMATION BELOW

INS CO: _____

INS ADDRESS: _____

ID: _____ GRP: _____

MEDICARE # _____

MEDICAID # _____

GYN - CYTOLOGY (PAP) ***** MEDICARE PATIENTS MUST SIGN SEPARATE ADVANCE BENEFICIARY NOTICE** – ATTACH TO THIS REQUISITION *******

TYPE
- ☐ CONVENTIONAL
- ☐ THIN PREP

PLEASE CHECK ONE

REASON AND SOURCE FOR PAP-SMEAR
- ☐ SCREENING ROUTINE WITH CERVIX V76.2
- ☐ SCREENING ROUTINE VAGINAL NO CERVIX V76.47
- ☐ SCREENING HIGH RISK V15.89
- ☐ ABNORMAL FOLLOWUP / DIAGNOSTIC PAP 795.___ ___
- ☐ MEDICAID WHP EXAM V25.09

FILL ABOVE

PLEASE CHECK ONE

CLINICAL INFORMATION
- ☐ PREGNANT V22.2
- ☐ POSTPARTUM V24.2
- ☐ POSTMENOPAUSAL V49.81
- ☐ HYSTERECTOMY V88.0*
- ☐ IRREGULAR MENSES 626.4
- ☐ POSTMENOPAUSAL BLEEDING 627.1
- ☐ OTHER (SPECIFY BELOW)

OTHER CLINICAL INFO (ICD-9 DIAG) _____

DATE & RESULTS OF LAST PAP _____

LMP DATE _____

ANCILLARY TESTING OFF THIN PREP VIAL
- ☐ GC/CHLAMYDIA V74.5
- ☐ HIGH RISK HPV TESTING IF ASCUS
- ☐ HIGH RISK HPV TESTING IF ASCUS OR ABOVE
- ☐ HIGH RISK HPV TESTING REGARDLESS OF PAP RESULTS
- ☐ HPV TYPE 16 & 18 REFLEX IF HIGH RISK POSITIVE

HPV ICD-9: V73.81

- ☐ ANCILLARY TESTING (SEPARATE SPECIMEN) _____

TISSUE BIOPSY AND NON-GYN CYTOLOGY

TIME OBTAINED FROM PATIENT: _____

TIME PLACED IN FORMALIN: _____

TYPE
- ☐ TISSUE _____
- ☐ CYTOLOGY (FNA, Fluid, etc.)_____

CLINICAL HISTORY

_____

_____

SOURCE

_____

_____

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION:

I HERBY AUTHORIZE AND REQUEST THAT AMARILLO PATHOLOGY ASSOC (APA) BILL ME OR MY INSURANCE CARRIER FOR PAYMENT OF SERVICES RENDERED. I HEREBY ASSIGN TO APA MY RIGHT AND INTEREST TO ANY PAYMENT MADE BY SUCH PAYORS IN PAYMENT OF THE SERVICES. APA MAY RELEASE ALL OR ANY PART OF MY PATIENT RECORD TO ANY PERSON OR ENTITY WHICH MAY BE LIABLE FOR ALL OR ANY PART OF APA'S CHARGES, INCLUDING BUT NOT LIMITED TO INSURANCE COMPANIES, WORKER'S COMPENSATION CARRIERS, MEDICARE, MEDICAID OR OTHER WELFARE FUNDS. I UNDERSTAND THAT I AM RESPONSIBLE FOR THESE CHARGES, INCLUDING ANY HEALTH INSURANCE DEDUCTIBLE OR COPAYMENT.

THE UNDERSIGNED CERTIFIES THAT I HAVE READ THIS RELEASE, I AM THE PATIENT OR PATIENT'S RESPONSIBLE PARTY, AND I AGREE TO THESE TERMS.

SIGNED _____ DATE _____

BILLING USE

_____

_____

_____

JE HAMOUS, MD AC HOOT, MD RA HALLOUSH, MD
RM TODD, MD DL SCHNEIDER, MD
JM HURLY, MD MD SENNETT, MD

CLIA 45D0967955

FOR SPECIMEN PICK-UP CALL: (806) 352-8294 FOR RESULTS CALL: (806) 212-5943 OR (806) 354-1754

AMARILLO PATHOLOGY ASSOCIATES LTD TAX ID: 75-2526006