

Anatomic Pathology Requisition

Patient Information	Name: _____ <small style="display: block; text-align: center;">Last First MI</small>	Sex M F	Date of Birth	Collection Date / Time / Initials	
	Address: Street or PO Box _____ <div style="text-align: center; font-size: 2em; opacity: 0.5;">REQUIRED</div>	Medical Record #:			
	City _____ State _____ Zip _____ Phone number _____ S M Sep D W _____ Marital Status _____ Soc. Sec. No. _____	Referring Physician: _____ <small style="display: block; text-align: center;">Last Name First Name</small> (If PA or NP, indicate supervising physician in parentheses) Physician's Signature: _____ CALL Report To: _____ FAX Report To: _____ PAGE Report To: _____			

Billing Information (Check one) Only required when sending samples		Diagnosis	Diagnosis/Signs/Symptoms in ICD-9 Format (Highest Specificity) <div style="text-align: center; font-size: 2em; opacity: 0.5;">REQUIRED</div> (Diagnosis must support medical necessity requirements.)
<input type="checkbox"/> Bill to Medicare No: _____ <input type="checkbox"/> Bill Patient Insurance	<input type="checkbox"/> Bill Doctor account <input type="checkbox"/> Bill to patient (Address given)		Insurance/Medicare/Medicaid Information: _____ Claims mailing address: _____ City _____ State _____ Zip _____ Policy No: _____ Group No: _____ If group, name of employer: _____ Insured or responsible party, if other than patient: _____ Insured Social Security Number: _____ Insured Date of Birth: _____ Patient relationship to insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Please attach a copy of patient's primary & secondary insurance information if available.

GYN CYTOLOGY	REQUIRED INFORMATION	NON-GYN CYTOLOGY
<input type="checkbox"/> GYN - ThinPrep Imaged Pap Test <input type="checkbox"/> GYNHR - ThinPrep Pap, HPV Regardless <input type="checkbox"/> GYNHX - ThinPrep Pap, HPV Reflex <input type="checkbox"/> GYG - ThinPrep Pap GC/Chlam <input type="checkbox"/> GYGHR - ThinPrep Pap GC/Chlam, HPV Regardless <input type="checkbox"/> GYGHX - ThinPrep Pap GC/Chlam, HPV Reflex HPV Test ONLY: <input type="checkbox"/> High Risk - HPVHR GC/Chlamydia Test ONLY- CGCP Source: <input type="checkbox"/> Urine <input type="checkbox"/> Swab <input type="checkbox"/> Thinprep Vial	Source: <input type="checkbox"/> Cervical <input type="checkbox"/> Endocervical <input type="checkbox"/> Vaginal Date LMP _____ <input type="checkbox"/> Pregnant <input type="checkbox"/> Post Partum <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Postmenopausal <input type="checkbox"/> Abnormal Vaginal Bleeding <input type="checkbox"/> Hormonal Rx <input type="checkbox"/> IUD <input type="checkbox"/> Caut <input type="checkbox"/> Previous Abnormal History: _____	<input type="checkbox"/> Breast <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Sputum <input type="checkbox"/> Cyst Asp. <input type="checkbox"/> Pleural Fluid <input type="checkbox"/> Solid Mass <input type="checkbox"/> Cell Block <input type="checkbox"/> Nipple Disc. <input type="checkbox"/> Abdominal Fluid <input type="checkbox"/> Neck Asp. <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Cell Block <input type="checkbox"/> Salivary <input type="checkbox"/> Urine <input type="checkbox"/> Lymph Node <input type="checkbox"/> CSF <input type="checkbox"/> Thyroid <input type="checkbox"/> Colonic Brush <input type="checkbox"/> Bronchial Wash <input type="checkbox"/> Esoph. Brush Lobe _____ <input type="checkbox"/> Gastric Brush <input type="checkbox"/> Bronchial Brush <input type="checkbox"/> Other _____ Lobe _____

HISTOLOGY-TISSUE SPECIMEN	SPECIMENS	LAB USE
Surgeon _____ Clinical History _____ Previous Surgical Specimen WakeMed _____ Other _____ Accompanying Cytology <input type="checkbox"/> Yes <input type="checkbox"/> No Preoperative Diagnosis _____ Postoperative Diagnosis _____	A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____	<div style="border: 1px solid black; padding: 5px; text-align: center;">Lab Accession No.</div> FOR BREAST SPECIMENS ONLY: Time specimen was resected: _____ Time specimen was placed in fixative: _____

AMBULATORY LAB DRAW LOCATIONS

WakeMed Oberlin

505 Oberlin Road, Suite 220
Raleigh, NC 27605

Phone: 919-350-8909
Fax: 919-350-8911

Hours: 7:30am - 5:30pm M-Th
7:30am - 3:30pm F

WakeMed Fuquay Varina

231 N. Judd Pkwy NE
Fuquay Varina, NC 27526

Phone: 919-235-1944
Fax: 919-235-1335

Hours: 7:00am - 4:00pm M-Th
7:00am - 3:00pm F

WakeMed Garner

400 U.S. Highway 70 East
Garner, NC 27529

Phone: 919-350-9680
Fax: 919-661-8413

Hours: 7:30am - 5:30pm M-Th
7:30am - 3:30pm F

WakeMed Medical Park of Cary

210 Ashville Ave, 1st floor
Cary, NC 27518

Phone: 919-350-6022
Fax: 919-350-6026

Hours: 7:30am - 5:30pm M-Th
7:30am - 3:30pm F

WakeMed Apex Healthplex

120 Healthplex Way
Apex, NC 27502

Phone: 919-350-4329
Fax: 919-363-8843

Hours: 7:30am - 5:30pm M-Th
7:30am - 3:30pm F

WakeMed Brier Creek Healthplex

8001 TW Alexander Drive
Raleigh, NC 27617

Phone: 919-350-9623
Fax: 919-957-1831

Hours: 7:30am - 5:30pm M-Th
7:30am - 3:30pm F

WakeMed North Physician Office Pavilion

10010 Falls of Neuse Road
Suite 101
Raleigh, NC 27614

Phone: 919-350-9680
Fax: 919-661-8413

Hours: 7:30am - 5:30pm M-Th
7:30am - 3:30pm F

HOSPITAL OUTPATIENT LOCATION

WakeMed Raleigh Medical Park

23 Sunnybrook Rd.
Raleigh, NC 27610

Phone: 919-350-8238
Fax: 919-661-7383

Hours: 7:00am - 5:00pm M-F

Advance Beneficiary Notice (ABN)

This section for office use only:

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

I believe that in your case, Medicare is likely to deny payment for the following {specify test(s)}: _____

_____ for the following reason(s):

Please check one that applies:

- Medicare does not pay for tests for screening purposes or routine exams
 Medicare does not pay for tests which are for "investigative or research use only"
 Medicare does not pay for services for the diagnosis code provided
 Medicare allows payment for this procedure only a limited number of times within a specific time period. WakeMed is not aware of other billings for this procedure by other health care providers.

Beneficiary Agreement: I have been notified by my physician / provider that he/ she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated.

CHECK ONE: If Medicare denies payment, I agree to be fully and personally responsible for payment to WakeMed.
 I decline to have the test(s).

Date of Service

Patient or Guarantor Signature

Witness