

CLIENT INFORMATION
PATIENT INFORMATION

(Please attach front and back of primary and secondary insurance card and patient face sheet)

 First Name: _____ Middle Name: _____ Last Name: _____
 Social Security #: _____ Date of Birth: _____ Sex: Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone #: _____ WorkPhone #: _____ Medical Record #: _____

BILLING INFORMATION (Please attach copy of insurance card)

Primary Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance <input type="checkbox"/> Patient <input type="checkbox"/> Client Bill	Secondary Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance <input type="checkbox"/> Patient <input type="checkbox"/> Client Bill
Insurance Name: _____	Insurance Name: _____
Policy Holder Name: _____ DOB: _____	Policy Holder Name: _____ DOB: _____
Employer: _____	Employer: _____
Policy#: _____ Group #: _____	Policy#: _____ Group #: _____
Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____
Referral #: _____	Referral #: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone #: _____	Phone #: _____

ORDERING

 Ordering Institution: _____ Ordering Physician: _____
 Reviewing Pathologist: _____ Referring Physician: _____ Treating Physician: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Secure Fax: _____ Email: _____
 Contact First Name: _____ Last Name: _____

SPECIMEN INFORMATION

 Specimen ID: _____ Number of Specimens: _____ Specimen Type: Voided Urine
 Collection Date: ____/____/____ Collection Time: ____/____/____ Bladder Wash

CLINICAL INFORMATION (Please attach to relevant clinical reports)
 Report Enclosed No Report Enclosed

 Clinical History: _____

 Diagnosis: _____

ICD-9 CODES: (ICD-9 Codes are provided for your convenience)

<input type="checkbox"/> 599.70 Hematuria, Unspecified	<input type="checkbox"/> 599.72 Microscopic Hematuria	<input type="checkbox"/> 188.9 Malignant neoplasm of Bladder
<input type="checkbox"/> 599.71 Gross Hematuria	<input type="checkbox"/> V10.51 History of Bladder Cancer	<input type="checkbox"/> Other: _____ (Please Provide Code)

TEST MENU-TECH ONLY ■ Your Pathologist

1001 <input type="checkbox"/> Urine Cytology	1002 <input type="checkbox"/> UroVysion®	1003 <input type="checkbox"/> Cytology + UroVysion®
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TEST MENU-GLOBAL ■ Cynogen Pathology Partners

1004 <input type="checkbox"/> Urine Cytology	1005 <input type="checkbox"/> UroVysion®	1006 <input type="checkbox"/> Cytology w/ Reflex to UroVysion® if negative	1007 <input type="checkbox"/> Cytology w/ Reflex to UroVysion® if Atypical or Suspicious
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ADDITIONAL REQUESTS / COMMENTS

Case #: Name:	Case #: Name:	Case #: Name:	Case #: Name:

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (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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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.