Account Information

WakeMed

Pathology Laboratory
3000 New Bern Avenue
Raleigh, North Carolina 27610
Phone: (919) 350-8242

Anatomic Pathology Requisition

Patient Information

Name: _____ *Last* _____ *First* _____ *MI*

Address: *Street or PO Box* REQUIRED

City _____ *State* _____ *Zip*

Phone number _____ S M Sep D W *Marital Status* _____ *Soc. Sec. No.* _____

Sex M F	Date of Birth	Collection Date / Time / Initials

Medical Record #:

Physician Information

Referring Physician: REQUIRED (_____)
Last Name *First Name*
(If PA or NP, indicate supervising physician in parentheses)

Physician's Signature: REQUIRED

CALL Report To: _____

FAX Report To: _____

PAGE Report To: _____

Billing Information *(Check one)*
Only required when sending samples

☐ Bill to Medicare No: _____ ☐ Bill Doctor account

☐ Bill Patient Insurance ☐ Bill to patient (Address given)

Insurance/Medicare/Medicaid Information: _____

Diagnosis

Diagnosis/Signs/Symptoms in ICD-9 Format (Highest Specificity)

REQUIRED

(Diagnosis must support medical necessity requirements.)

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: ☐ Spouse ☐ Child ☐ Other

Please attach a copy of patient's primary & secondary insurance information if available.

GYN CYTOLOGY

☐ GYN - ThinPrep Imaged Pap Test
☐ GYNHR - ThinPrep Pap, HPV Regardless
☐ GYNHX - ThinPrep Pap, HPV Reflex
☐ GYG - ThinPrep Pap GC/Chlam
☐ GYGHR - ThinPrep Pap GC/Chlam, HPV Regardless
☐ GYGHX - ThinPrep Pap GC/Chlam, HPV Reflex

HPV Test ONLY:
☐ High Risk - HPVHR

GC/Chlamydia Test ONLY- CGCP
Source: ☐ Urine ☐ Swab ☐ Thinprep Vial

REQUIRED INFORMATION

Source:
☐ Cervical
☐ Endocervical
☐ Vaginal

Date LMP _____
☐ Pregnant
☐ Post Partum
☐ Hysterectomy
☐ Postmenopausal
☐ Abnormal Vaginal Bleeding
☐ Hormonal Rx
☐ IUD
☐ Caut
☐ Previous Abnormal History: _____
_____

NON-GYN CYTOLOGY

☐ Breast ☐ RT ☐ LT
☐ Cyst Asp.
☐ Solid Mass
☐ Nipple Disc.
☐ Neck Asp. ☐ RT ☐ LT
☐ Salivary
☐ Lymph Node
☐ Thyroid
☐ Bronchial Wash
Lobe _____
☐ Bronchial Brush
Lobe _____

☐ Sputum
☐ Pleural Fluid
☐ Cell Block
☐ Abdominal Fluid
☐ Cell Block
☐ Urine
☐ CSF
☐ Colonic Brush
☐ Esoph. Brush
☐ Gastric Brush
☐ Other _____

HISTOLOGY-TISSUE SPECIMEN

Surgeon _____
Clinical History

Previous Surgical Specimen
WakeMed _____ Other _____
Accompanying Cytology ☐ Yes ☐ No

Preoperative Diagnosis

Postoperative Diagnosis

SPECIMENS

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____

LAB USE

Lab Accession No.

FOR BREAST SPECIMENS ONLY:
Time specimen was resected: _____
Time specimen was placed in fixative: _____

LOCATIONS

WakeMed Raleigh Medical Park
23 Sunnybrook Road
Raleigh, NC 27610

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

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

WakeMed Cary Hospital
1900 Kildaire Farm Road
Cary, NC 27518

Phone: 919-350-2370
Fax: 919-350-2375

Hours: 6:00am - 6:00pm M-F
9:00am - 1:00pm Saturday

WakeMed North Healthplex
10000 Falls of Neuse Road
Raleigh, NC 27614

Phone: 919-350-1350
Fax: 919-350-1355

Hours: 8:00am - 4:30pm M-F

WakeMed Apex Healthplex
120 Healthplex Way
Apex, NC 27502

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

Hours: 8:00am - 4:30pm M-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-F

WakeMed Brier Creek Healthplex
8001 TW Alexander Drive
Raleigh, NC 27617

Phone: 919-350-9623
Fax: 919-598-0665

Hours: 7:30am - 4:30pm 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*