OSF System Laboratory Client Cytology/Pathology requisition form instructions

Please utilize this requisition to submit Cytology/Surgical Pathology specimens only. Any clinical tests (cultures, etc.) need to be submitted utilizing the Client Clinical (Green) requisition.

Requisition Field	Instructions/Tips for filling out	Required field?
① Bill to Insurance or Client/Office bill	Check/select one or the other. If Bill to Insurance, please attach a copy of insurance card, front and back. **Note: OSF must bill according to the option you check (client takes full accountability for billing type selected).**	YES
② Patient's Name (Last and First)	Clearly document patient's full legal last and first name. Do not use nicknames.	YES
② MI-Patient's Middle initial	Document on form if known	NO
② Date of Birth	Patient's Date of Birth as it appears on their Birth Certificate	YES
② Patient's Address	Clearly document patient's address	NO
② Patient's phone number	Patient's primary phone number	NO
② Patient's Social Security Number	Patient's Social Security Number. While this field is not mandatory, providing it would act as an additional patient identifier.	NO
③ Advanced Beneficiary Notice	You **MUST** issue an ABN when there is any possibility to expect that the test is not deemed reasonable and necessary under Medicare Program standards. If you believe that a test subject to a frequency limitation exceeds the Medicare Program frequency limits for test ordering, you **MUST** issue an ABN before you collect and order the test. With this requirement, you must evaluate test frequency limits and look up how many times the test was ordered during the specific timeframe for that patient. Failure to submit an ABN to OSF in these cases, resulting in claim denial, will result in a service charge to your office.	YES
④ Authorizing Provider	Clearly document Authorizing Provider's complete first and last name. **Dr. Bob or Dr. Smith are not acceptable**.	YES
⑤ Duplicate Report	If you would like a duplicate report sent, provide a full first and last name, along with current contact information.	NO
⑥ Collector's Initials	Clearly document the initials of the person collecting the sample	YES
⑦ Collected Date	Please denote the collection date	YES
⑧ Collection Time	Please record the time the specimen was collected and/or placed in fixative	YES
⑨ ICD Diagnosis Code	**ICD Code is required.** All requests must be accompanied by a valid alpha-numeric ICD diagnosis code, as to establish medical necessity for tests ordered. If the ICD code is not provided and/ or does not meet coverage requirements, this can result in test and/or reimbursement delays.	YES
⑩ Gynecologic Cytology	Please mark the collection site of the pap specimen. Also denote the test you wish to be performed. If a Pap ONLY is desired, simply mark the collection site.	YES

(11) Gynecological History	Please mark if the test is a screening or diagnostic in nature. Refer to CMS NCD 210.2 for Pap Screening medical necessity and frequency determinations. See CMS NCD 190.2 for Pap Diagnostic medical necessity criteria. If there is any risk that a frequency limit will be exceeded (you must look up in patient's records), an ABN must be issued and provided to OSF with the sample.	YES
(12) Non-Gynecologic Cytology	Fill in this area if a non-gynecologic sample is sent for analysis. This section is mandatory if a non-gynecologic sample is sent.	YES
(13) Surgical Pathology	Please be specific as to the laterality of the specimen site (right, left, etc.) and the specific origin (source). Denote how the sample was obtained (procedure) and include any pertinent diagnosis codes. This section is mandatory if a surgical pathology sample is sent.	YES