

105 Westwood Place, Suite 200
Brentwood, Tennessee 37027
www.pricare.com

615 | 370-6500 phone
370-6501 fax

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FACSIMILE

TO: Laureen (CRN), Diane Lindler, RN, CPC, Kathy Palmerton, Jeff Richael

COMPANY: _____

FAX NUMBER: (609) 965-6547, (614) 488-4236, (916) 924-9617, and (412) 621-7614

FROM: Katherine Abel, CPC

DATE: 04/26/00

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If you have any problems receiving this fax, please contact: Donna Brown at 615.370.6500

Attached is the waiver form for screening pap smears, this is from the North Carolina Cigna Medicare Provider Manual (April 1999), page 137. I am also attaching one that I have re typed incase the first one is not clear.

Katherine Abel, CPC

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CIGNA HealthCare Medicare Administration
Part B Provider Manual – April 1999

for patients in any setting if the laboratory screening personnel suspect an abnormality, and the physician reviews and interprets the Pap smear.

Advance Beneficiary Notice

HCFA has approved specific advance beneficiary notice (waiver of liability) language that may be used by physicians and laboratories with respect to the provision of screening pap smears. The

beneficiary agreement section of the notice must have two choices:

- One for a beneficiary who believes she has not received a screening pap smear within the preceding three years.
- One for a beneficiary who believes she has received a screening pap smear within the preceding three years.

Physician/Laboratory Advance Beneficiary Notice

"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. Specifically, Medicare will deny payment for a **Screening Pap Smear** if you have had one during the last three years.

Beneficiary Agreement 1:

"I have been notified by my physician/laboratory that Medicare will deny payment for a **Screening Pap Smear** if I have had one during the last three years. I believe that I have not had a **Screening Pap Smear** during the last three years. If I am mistaken and Medicare denies payment, I agree to be personally and fully responsible for payment."

Signed, _____
(Beneficiary Signature)

Date _____

Beneficiary Agreement 2:

"I have been notified by my physician/laboratory that Medicare will deny payment for a **Screening Pap Smear** if I have had one during the last three years. I believe that I have had a **Screening Pap Smear** during the last three years. If Medicare denies payment, I agree to be personally and fully responsible for payment."

Signed, _____
(Beneficiary Signature)

Date _____

Screening Pap Smear Release

“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. Specifically, Medicare will deny payment for a **Screening Pap Smear if you have had one during the last three years.**”

Beneficiary Agreement 1:

“I have been notified by my physician/laboratory that Medicare will deny payment for a **Screening Pap Smear if I have had one during the last three years.** I believe that I have not had a **Screening Pap Smear during the last three years.** If I am mistaken and Medicare denies payment, I agree to be personally and fully responsible for payment.”

Signed, _____
(Beneficiary Signature)

Date _____

Beneficiary Agreement 2:

“I have been notified by my physician/laboratory that Medicare will deny payment for a **Screening Pap Smear if I have had one during the last three years.** I believe that I have had a **Screening Pap Smear during the last three years.** If Medicare denies payment, I agree to be personally and fully responsible for payment.”

Signed, _____
(Beneficiary Signature)

Date _____