Anthem

ABNORMAL PAP SMEAR QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Date(s) of abnormal pap smear(s)? _____

2. Diagnosis (please try to use classifications below when possible):

   ___ Class 1: Normal cells but viral infections, bacteria or yeast
   ___ Class 2: Mild dysplasia, atypical cells, inflammation,
   ___ Class 3: Moderate dysplasia, abnormal cells, (CIN I or CIN II)
   ___ Class 4: Severe dysplasia, carcinoma in-situ, (CIN III)
   ___ Class 5: Malignant cells (Cancer)

3. Was a cervical biopsy performed? Yes ____ No _____Results _____

4. Please indicate type of treatment(s), if any, and date:

   ___**Colposcopy** Date: _____
   ___ **Laser vaporization of cervix (laser surgery)** Date: _____
   ___ **Cryotherapy of cervix (freeze cervix)** Date: _____
   ___ **Conization (cone, LEEP)** Date: _____
   ___ **Hysterectomy** Date: _____
   ___ **No treatment but repeat pap smear**

   Date of repeat pap smear: _____
   Results (use class): _____

   Medication prescribed? Yes _____ No _____

   Name of Medication: _____ Dosage:_____ (Date last used) _____

5. Have you had a follow up pap smear since the original diagnosis or treatment? Yes _____ No _____

   If yes, when: _____
   Results (use class): _____

6. Name and address of treating physician: _____

   _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

_____ _____
Signature of person treated (or parent/guardian if under 18) Date

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