

**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, (CIN I)
- \_\_\_ Class 3: Moderate dysplasia, abnormal cells, (CIN II)
- \_\_\_ Class 4: Severe dysplasia, carcinoma in-situ, (CIN III)
- \_\_\_ Class 5: Malignant cells (Cancer)

3. Was a cervical biopsy performed? Yes \_\_\_\_\_ No \_\_\_\_\_

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