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DERMATOPATHOLOGY

 e-mail: dermatopathology@lists.stanford.edu
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Payor <input type="checkbox"/> Patient <input type="checkbox"/> PPO <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Client <input type="checkbox"/> Other	 DIAGNOSTIC TESTS • DERMATOPATHOLOGY
	HMO Insurance Authorization # _____

Patient Name (Last)	(First)	DOB
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Social Security No. (Use last 6 digits only)	Sex	Patient's Phone Number
	M F ()	

Patient Address	City	State	Zip Code
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Practice Name & Address	
Phone No.	Fax No.

Ordering Physician - Print Name	NPI #
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Patient/health plan will receive 2 bills; technical (lab) and professional (M.D.) charges are billed separately.

Insurance Info: Attach a copy of front & back of Insurance card or face sheet.

For Lab Use Only	
Requisition #	Signature
	Date

Copies to: (Name & Address, Fax & Phone)	
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SPECIMEN INFORMATION
CLINICAL INFORMATION (Use extra sheets if more than 3 specimens)

SPECIMEN A:

 Alopecia Protocol
 Lesional Biopsy
 Perilesional Biopsy
 Direct Immunofluorescent Stain/Stains (DIF)
 Indirect Immunofluorescent Stain/Stains (IIF)
 Electron Microscopy (EM)
 Send Duplicate Slide

Site / Slide Number:	Collection Date:
Clinical Findings:	

Clinical Photos:
<input type="checkbox"/> Enclosed with Specimen
<input type="checkbox"/> Sent Digitally
ICD-9 Code(s):
1. _____
2. _____

SPECIMEN B:

 Alopecia Protocol
 Lesional Biopsy
 Perilesional Biopsy
 Direct Immunofluorescent Stain/Stains (DIF)
 Indirect Immunofluorescent Stain/Stains (IIF)
 Electron Microscopy (EM)
 Send Duplicate Slide

Site / Slide Number:	Collection Date:
Clinical Findings:	

Clinical Photos:
<input type="checkbox"/> Enclosed with Specimen
<input type="checkbox"/> Sent Digitally
ICD-9 Code(s):
1. _____
2. _____

SPECIMEN C:

 Alopecia Protocol
 Lesional Biopsy
 Perilesional Biopsy
 Direct Immunofluorescent Stain/Stains (DIF)
 Indirect Immunofluorescent Stain/Stains (IIF)
 Electron Microscopy (EM)
 Send Duplicate Slide

Site / Slide Number:	Collection Date:
Clinical Findings:	

Clinical Photos:
<input type="checkbox"/> Enclosed with Specimen
<input type="checkbox"/> Sent Digitally
ICD-9 Code(s):
1. _____
2. _____