

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


Patient Name (Last) (First)		DOB
MRN or Unique Identifier	Sex M F ()	Patient's Phone Number

Patient/health plan will receive 2 bills; technical (lab) and professional (M.D.) charges are billed separately.

Patient Address	City	State	Zip Code
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Medicare will only pay for services that are reasonable and necessary for the diagnosis and treatment of the patient. The physician must specify an ICD9 code to indicate the medical necessity of each test requested.

Practice Name & Address	
Phone No.	Fax No.

For Lab Use Only Requisition #  0000000000
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Patient Name (Last, First) DOB: _____ Site: _____ 0000000000 Date: _____
Patient Name (Last, First) DOB: _____ Site: _____ 0000000000 Date: _____
Patient Name (Last, First) DOB: _____ Site: _____ 0000000000 Date: _____

Ordering Physician - Print Name	NPI #	Signature	Date
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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 Biopsy
 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:	
SIZE:	CLINICAL DDX:

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

SPECIMEN B:

Alopecia Biopsy
 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:	
SIZE:	CLINICAL DDX:

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

SPECIMEN C:

Alopecia Biopsy
 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:	
SIZE:	CLINICAL DDX:

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