



TISSUE EXAMINATION REQUEST FORM

2904 Westcorp Blvd., Suite 107, Huntsville, AL 35805 (256) 533-1480

Medical Directors:
 Walter G. Grundy, M.D.
 Frank A. Honkanen, M.D.
 J.C. Harrison, M.D., Ph.D.
 J. Craig Romer, M.D.
 Mark W. Teague, M.D.
 Kathryn L. Lane, M.D.
 Priya S. Gore, M.D.
 Cheryl M. Kirk, M.D.
 R. Jemison Moore III, M.D.
 Stephanie L. Jackson, M.D.
 Aimee' A. League, M.D.
 L. Allen Perkins, M.D.
 Carrie S. Knight, M.D.
 William K. Brix, M.D.

PATIENT NAME (LAST, FIRST, MIDDLE) ①			
PATIENT SOCIAL SECURITY # ② -		DATE OF BIRTH ③	AGE ④
PATIENT PHONE # ()		CHART/PATIENT ID#	
PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT ⑥			
STREET ADDRESS OF INSURED/RESPONSIBLE PARTY ⑦			
CITY	STATE	ZIP	

DATE COLLECTED ⑩	TIME A.M. P.M.
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REFERRING PHYSICIAN / NPI

REQUIRED BILLING INFO...ATTACH COPY OF INSURANCE CARD(S)

⑧ RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	
MEDICARE NUMBER ⑨ - Suffix	
MEDICAID NUMBER ⑩ State	
PRIMARY INSURANCE CARRIER ⑪	
CONTRACT # ⑫	GROUP #
OTHER INSURANCE CARRIER ⑬	
CONTRACT # ⑭	GROUP #
INSURED SOCIAL SECURITY # (if not patient) ⑮ -	Employer Name / Work Phone ⑯

① SOURCE OF SPECIMEN: _____

② CLINICAL DIAGNOSIS _____

SIGNS & SYMPTOMS: _____

PATIENT HISTORY / REMARKS _____

⑰ PATIENT SIGNATURE REQUIRED

I authorize the release of any medical and insurance information about me to insurance carriers involving claims made for the services requested by my physician. I understand that these services will be billed separately by the provider. Unless covered by Medicare, Medicaid, or carrier for which the provider has agreed to accept payment in full, I agree to be responsible for payment in full within thirty days of receiving a statement, and to pay any additional fees to collect payment, even if my insurance is filed, or if my insurance decides that these services are "not reasonable or medically necessary".

_____ Date _____ Patient's Signature

Required Patient Information:

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| <ol style="list-style-type: none"> 1. Patient Name 2. Patient Social Security Number 3. Date of Birth 4. Sex 5. Patient Phone Number 6. Responsible Party Name 7. Insured/Responsible Party Address 8. Mark "Relationship" Box 9. Medicare / Medicaid Number 10. Insurance Name (other than Medicare/Medicaid) 11. Insurance Contract Number, Group Number 12. Secondary Insurance Name 13. Secondary Contract Number, Group Number | <ol style="list-style-type: none"> 14. Insured Social Security Number (if not the patient) 15. Employer Name/Phone Number 16. Record the Collection date/Time 17. Obtain Patient Release Authorization <p>A Complete the test request area</p> <ol style="list-style-type: none"> 1. Source of Specimen 2. Pertinent clinical history <ul style="list-style-type: none"> • Clinical Diagnosis/ICD9 Codes • Signs & Symptoms • Patient History / Remarks |
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