



PATHOLOGY
a s s o c i a t e s

TISSUE EXAMINATION REQUEST FORM

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

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

DATE COLLECTED	TIME	A.M. P.M.
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<p>REFERRING PHYSICIAN / NPI</p> <p>Crestwood Medical Center One Hospital Drive Huntsville, AL 35801 CRW</p>

SOURCE OF SPECIMEN: _____

HISTORY/ICD9: _____

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

FROZEN SECTION DX: _____

SEND FOR FLOW _____

HOLD FLOW _____

CHROMOSOME ANALYSIS _____

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