DERMATOPATHOLOGY REQUEST FORM

PATHOLOGY associates

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

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.

REFERRING PHYSICIAN / NPI

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

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT	
MEDICARE NUMBER | | |—| | |—| | | | | Suffix	
MEDICAID NUMBER | | | | | | | | | | | | | | | | State	
PRIMARY INSURANCE CARRIER	
CONTRACT #	GROUP #
OTHER INSURANCE CARRIER	
CONTRACT #	GROUP #
INSURED SOCIAL SECURITY # (if not patient) | | |—| | |—| | | | |	Employer Name / Work Phone

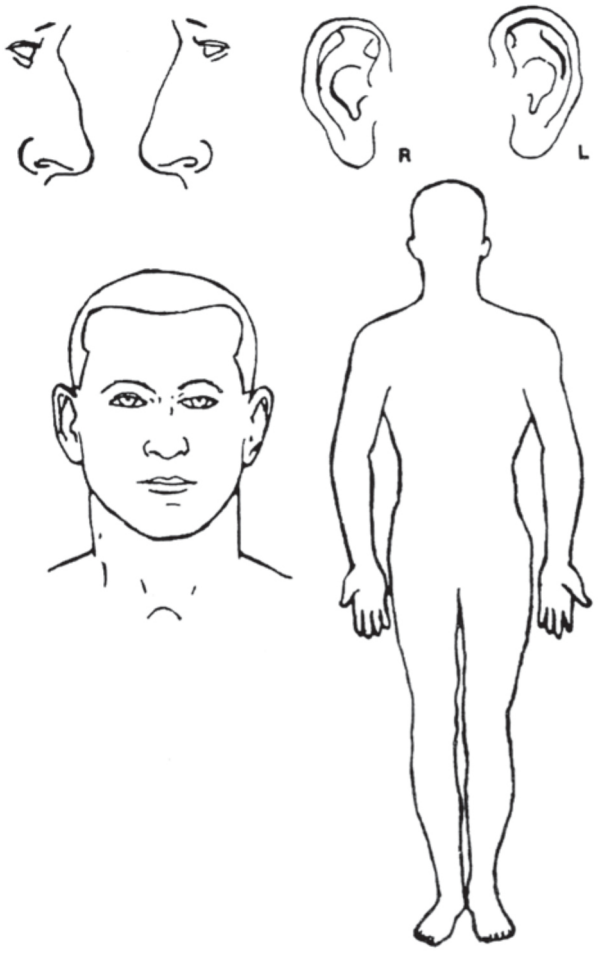
PATIENT SIGNATURE REQUIRED

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 _____

SITE, OPERATIVE PROCEDURE, AND CLINICAL DIAGNOSIS

MARK SITE(S)



☐ FRONT ☐ REAR

CLINICAL HISTORY

ICD-9 Code(s): _____

FORWARD BILLING INFORMATION WITH SPECIMEN