

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)			CLIENT INFORMATION		
Last Name	First	MI			
Address	Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F			
City	SS #				
State	Zip	Home Phone			
Hospital/Physician Office Patient ID #		Accession #			

MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)		ORDERING PHYSICIAN CONTACT	
BILL TO: <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient		Physician Name	
PATIENT STATUS: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____		Physician NPI#	
PRIMARY: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Physician Phone	
Subscriber Last Name		Physician Email	
Beneficiary / Member #		Date Collected: ____/____/____ Collected By: _____	
Claims Address		<input type="checkbox"/> Call Results to phone number: (____) _____	
SECONDARY: <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach)		<input type="checkbox"/> Fax report to: (____) _____	
DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____			

Consultation on Prepared Slides/Blocks

SPECIMEN A

Check off Appropriate Type of Biopsy:

- Punch
- Punch Excision
- Shave
- Shave Excision
- Curettings
- Excision
- Wide Excision

Margins: Yes No

Biopsy Site: _____

Clinical History: _____

Additional Tests:

- Direct Immunofluorescence
- Immunohistochemistry

Stain: _____

- Melanoma FISH
- BRAF V600
- T-Cell Clonality (*TCRB* and *TCRG*)
- B-Cell Clonality (*IGH* and *IGK*)
- Other: _____

SPECIMEN B

Check off Appropriate Type of Biopsy:

- Punch
- Punch Excision
- Shave
- Shave Excision
- Curettings
- Excision
- Wide Excision

Margins: Yes No

Biopsy Site: _____

Clinical History: _____

Additional Tests:

- Direct Immunofluorescence
- Immunohistochemistry

Stain: _____

- Melanoma FISH
- BRAF V600
- T-Cell Clonality (*TCRB* and *TCRG*)
- B-Cell Clonality (*IGH* and *IGK*)
- Other: _____

SPECIMEN C

Check off Appropriate Type of Biopsy:

- Punch
- Punch Excision
- Shave
- Shave Excision
- Curettings
- Excision
- Wide Excision

Margins: Yes No

Biopsy Site: _____

Clinical History: _____

Additional Tests:

- Direct Immunofluorescence
- Immunohistochemistry

Stain: _____

- Melanoma FISH
- BRAF V600
- T-Cell Clonality (*TCRB* and *TCRG*)
- B-Cell Clonality (*IGH* and *IGK*)
- Other: _____