

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name	First	MI
Address	Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F
City	SS #	
State	Zip	Home Phone
MRN/Hospital/Physician Office Patient ID #	Accession/Case #	

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)

BILL TO: Client/Institution Medicare Insurance (Complete insurance information below) Patient

PATIENT STATUS: Inpatient Outpatient Non-Hospital Patient Hospital discharge date: ____/____/____

PRIMARY: Medicare Medicaid Other Ins. _____ Self Spouse Child

Subscriber Last Name	First	MI	
Beneficiary / Member #	Group #		
Claims Address	City	State	Zip

SECONDARY: No Yes (if Yes, please attach) **ABN:** No Yes

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____

CLIENT INFORMATION

ORDERING PHYSICIAN CONTACT

Physician Name _____

Physician NPI# _____

Physician Phone _____

Physician Email _____

Date Collected: ____/____/____

Collected By: _____

Call Results to phone number: (____) _____

Fax report to: (____) _____

Test Performed: Gross examination and diagnostic interpretation

SPECIMEN A

Biopsy Site: _____					Clinical History: _____
Collection Date: _____	Type of Fixative: _____	Date in Fixative: _____	Check off appropriate type of biopsy:	Additional Tests:	_____
_____	<input type="checkbox"/> Alcohol	_____	<input type="checkbox"/> Punch	<input type="checkbox"/> Direct Immunofluorescence	_____
_____	<input type="checkbox"/> Fresh tissue	_____	<input type="checkbox"/> Punch Excision	<input type="checkbox"/> Immunohistochemistry	_____
Collection Time: _____	<input type="checkbox"/> Formalin	Time in Fixative: _____	<input type="checkbox"/> Shave	Stain: _____	_____
_____	<input type="checkbox"/> Michel's	_____	<input type="checkbox"/> Shave Excision	<input type="checkbox"/> Melanoma FISH	_____
			<input type="checkbox"/> Curettings	<input type="checkbox"/> Melanoma NGS (includes <i>KIT</i> , <i>NRAS</i> , <i>BRAF V600</i>)	_____
			<input type="checkbox"/> Excision	<input type="checkbox"/> T-Cell Clonality (<i>TCRB</i> and <i>TCRG</i>)	_____
			<input type="checkbox"/> Wide Excision	<input type="checkbox"/> B-Cell Clonality (<i>IGH</i> and <i>IGK</i>)	_____
			Margins: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other: _____	_____

SPECIMEN B

Biopsy Site: _____					Clinical History: _____
Collection Date: _____	Type of Fixative: _____	Date in Fixative: _____	Check off appropriate type of biopsy:	Additional Tests:	_____
_____	<input type="checkbox"/> Alcohol	_____	<input type="checkbox"/> Punch	<input type="checkbox"/> Direct Immunofluorescence	_____
_____	<input type="checkbox"/> Fresh tissue	_____	<input type="checkbox"/> Punch Excision	<input type="checkbox"/> Immunohistochemistry	_____
Collection Time: _____	<input type="checkbox"/> Formalin	Time in Fixative: _____	<input type="checkbox"/> Shave	Stain: _____	_____
_____	<input type="checkbox"/> Michel's	_____	<input type="checkbox"/> Shave Excision	<input type="checkbox"/> Melanoma FISH	_____
			<input type="checkbox"/> Curettings	<input type="checkbox"/> Melanoma NGS (includes <i>KIT</i> , <i>NRAS</i> , <i>BRAF V600</i>)	_____
			<input type="checkbox"/> Excision	<input type="checkbox"/> T-Cell Clonality (<i>TCRB</i> and <i>TCRG</i>)	_____
			<input type="checkbox"/> Wide Excision	<input type="checkbox"/> B-Cell Clonality (<i>IGH</i> and <i>IGK</i>)	_____
			Margins: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other: _____	_____