

DERMATOPATHOLOGY REQUISITION

lease legibly complete all fields to ensure timely results

Patient Information Patient ID / MRN Patient Name						
Patient Name Last Date of Birth	Patient Information					
Date of Birth Last	Patient ID / MRN					
Date of Birth Date of Birth	Patient Name					
Patient Address Address Address Apartment, Suite, Other (Optional) County City Tip Non-US Address Apartment, Suite, Other (Optional) Apartment States, please provide their home address. Patient Phone Billing / Insurance Client / Institution PLEASE INCLUDE A COPY OF THE PATIENT'S INSURANCE CARD if a copy of the patient's insurance card is not available, please fill out the information belows Policy Holder's Name it address. Medicare HIC Number Relationship to Patient Medicare HIC Number Medicare Company If applicable Medicare Company If applicable Claims Address Street City Yes (attach a copy) No 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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.		First				Middle Initial
Patient Address Address Address Apartment, Suite, Other (Optional) County City Tip Non-US Address Apartment, Suite, Other (Optional) Apartment States, please provide their home address. Patient Phone Billing / Insurance Client / Institution PLEASE INCLUDE A COPY OF THE PATIENT'S INSURANCE CARD if a copy of the patient's insurance card is not available, please fill out the information belows Policy Holder's Name it address. Medicare HIC Number Relationship to Patient Medicare HIC Number Medicare Company If applicable Medicare Company If applicable Claims Address Street City Yes (attach a copy) No 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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.		Last				
Patient Address Address	Date of Birth	, ,		Sex		☐ Male
Address Apartment, Suite, Other (Optional) County City Zip Non-US Address If the patient lives outside of the United States, please provide their home address. Patient Phone Billing / Insurance Client / Institution Medicare Client / Institution PLEASE INCLUDE A COPY OF THE PATIENT'S INSURANCE CARD If a copy of the patient's insurance card is not available, please fill out the information below. Policy Holder's Name It different than no patient Medicare HIC Number Relationship to Patient Insurance Company Advance Company Policy Number Group Number Claims Address Street City Secondary Insurance? Yes (attach a copy) No 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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.		month day	year year			☐ Female
Apartment. Suite, Other (Optional) County	Patient Address					
Non-US Address If the patient lives outside of the United States, please provide their home address.		Address				
City		Apartment, Suite, Other (Optional)				
City						
Non-US Address If the patient lives outside of the United States, please provide their home address.		County				
### If the patient lives outside of the United States, please provide their home address. Patient Phone		City				Zip
Patient Phone Billing / Insurance Client / Institution	□ Non-US Address					
Patient Phone Billing / Insurance						
Client / Institution						
Client / Institution Medicare Insurance Patient	Patient Phone					
PLEASE INCLUDE A COPY OF THE PATIENT'S INSURANCE CARD If a copy of the patient's insurance card is not available, please fill out the information below: Policy Holder's Name If different than the patient Relationship to Patient Spouse Dependent Other: Medicare HIC Number	Billing / Insurance					
Policy Holder's Name It different than the patient Relationship to Patient Spouse Dependent Other: Medicare HIC Number It applicable	☐ Client / Institution	☐ Medicare	□ Insurano	ce	□ Patie	ent
Policy Holder's Name If different than the patient Spouse Dependent Other: Medicare HIC Number If applicable Medicare HIC Number If applicable Medicaid Number OHIO CNILY If applicable Insurance Company If applicable Policy Number Group Number Claims Address Street State Zip Advanced Beneficiary Notice (ABN)? Secondary Insurance? No Yes (attach a copy) No No No MEDICAL NECESSITY NOTICE: When ordering test 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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History 1.						
Medicaid Number Medicaid Number	Policy Holder's Name	Surance Card is not av	aliable, please	mi out	the mom	Tation below:
Medicaid Number OHIO QNLY If applicable	Relationship to Patient	☐ Spouse ☐ Dep	endent 🗆 0	ther:		
Insurance Company If applicable Policy Number Group Number Claims Address Street City State Zip Advanced Beneficiary Notice (ABN)? Yes (attach a copy) No Yes (attach a copy) No 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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.						
Policy Number						
Group Number Claims Address Street City Secondary Insurance? Yes (attach a copy) No 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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.						
Claims Address Street City State Zip Advanced Beneficiary Notice (ABN)? Yes (attach a copy) NO 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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.	Policy Number					
Advanced Beneficiary Notice (ABN)? Yes (attach a copy) No Yes (attach a copy) No No Notice (ABN)? 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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.	Group Number					
Advanced Beneficiary Notice (ABN)? Yes (attach a copy) No Yes (attach a copy) No 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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.	Claims Address					
Advanced Beneficiary Notice (ABN)? Yes (attach a copy) No Yes (attach a copy) No 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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.		Street				
Yes (attach a copy)		City			State	Zip
Yes (attach a copy)	Advanced Beneficiary N	otice (ABN)?	Secondary	v Insu	rance?	
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. Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.	_		· · · · · · ·			□ No
Clinical Information & Diagnosis Codes Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.	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					
Reason for Testing / Brief Clinical History ICD-10 Code(s) 1. 2.						
ICD-10 Code(s) 1. 2.	Reason for Testing /	lagnosis ocacs				
2.						
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3. 4.	ICD-10 Code(s)	1.		2.		
		3.		4.		

	riease l egibly complete <u>all</u> t	icids to ensure timely results.			
Submitter – Client / Org	anization				
Submitter Name					
Phone					
Fax					
Submitter Address					
	Street				
	City State Zip				
	Country				
Referring Provider					
Provider Name					
	First Middle Initial				
	Last				
NPI					
Email					
Phone					
☐ Additional Fax Select to fax a second report.					
Specimen A					
Collection Date	/ / month day year	Time: □ AM			
Biopsy Site	monan day year				
Type of Biopsy	☐ Curettings ☐ Punch ☐ Shave				
	☐ Excision ☐ Punch Excision ☐ Shave Excision ☐ Wide Excision				
Date in Fixative	//	Time :			
	month day year	□ PM			
Fixative Type	☐ Formalin☐ Fresh Tissue	☐ Michel's Media for DIF ☐ Alcohol			
Testing to Perform	☐ Gross Examination & Diagnostic Interpretation	☐ Other:			
- Additional Tests	☐ FISH for Cutaneous	☐ T-Cell Clonality TCRB & TCRG			
	Melanoma <i>CMFISH</i> ☐ Direct	TCBMDO □ B-Cell Clonality IGH & IGK			
	Immunofluorescense BCBMDO				
	☐ IHC Stain:				
Specimen B					
Collection Date	//	Time:_			
Johnston Date	month day year	PM			
Biopsy Site					
Type of Biopsy	☐ Curettings ☐ Punch ☐ Shave				
	☐ Excision ☐ Punch Excision ☐ Shave Excision ☐ Wide Excision				
Date in Fixative		□ AM			
	month day year	Time: □ PM			
Fixative Type	☐ Formalin ☐ Fresh Tissue	☐ Michel's Media for DIF ☐ Alcohol			
Testing to Perform	☐ Gross Examination & Diagnostic Interpretation	☐ Other:			
- Additional Tests	☐ FISH for Cutaneous	☐ T-Cell Clonality TCRB & TCRG			
	Melanoma CMFISH	TCBMDO			
	☐ Direct ☐ B-Cell Clonality IGH & IGK BCBMDO				
	☐ IHC Stain:				

Payment terms are net 30 days.