

Patient Information			
Patient ID / MRN			
Patient Name		First	Middle Initial
		Last	
Date of Birth	____ / ____ / ____ <small>month day year</small>	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Patient Address			
Address			
Apartment, Suite, Other (Optional)			
County			
City		Zip	
<input type="checkbox"/> Non-US Address <i>If the patient lives outside of the United States, please provide their home address.</i>			
Patient Phone			
Billing / Insurance			
<input type="checkbox"/> Client / Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance <input type="checkbox"/> Patient			
PLEASE INCLUDE A COPY OF THE PATIENT'S INSURANCE CARD <i>If a copy of the patient's insurance card is not available, please fill out the information below:</i>			
Policy Holder's Name <i>If different than the patient</i>			
Relationship to Patient		<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other:	
Medicare HIC Number <i>If applicable</i>			
Medicaid Number <small>OHIO ONLY If applicable</small>			
Insurance Company <i>If applicable</i>			
Policy Number			
Group Number			
Claims Address			
Street			
City		State	Zip
Advanced Beneficiary Notice (ABN)?		Secondary Insurance?	
<input type="checkbox"/> Yes (attach a copy) <input type="checkbox"/> No		<input type="checkbox"/> Yes (attach a copy) <input type="checkbox"/> No	
<small>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.</small>			
Clinical Information & Diagnosis Codes			
Reason for Testing / Brief Clinical History			
ICD-10 Code(s)		1.	2.
		3.	4.

Submitter – Client / Organization			
Submitter Name			
Phone			
Fax			
Submitter Address			
Street			
City		State	Zip
Country			
Referring Provider			
Provider Name		First	Middle Initial
		Last	
NPI			
Email			
Phone			
<input type="checkbox"/> Additional Fax <small>Select to fax a second report.</small>			
Specimen A			
Collection Date	____ / ____ / ____ <small>month day year</small>	Time ____:____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Biopsy Site			
Type of Biopsy			
<input type="checkbox"/> Curettings <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Punch Excision <input type="checkbox"/> Shave Excision <input type="checkbox"/> Wide Excision			
Date in Fixative	____ / ____ / ____ <small>month day year</small>	Time ____:____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Fixative Type			
<input type="checkbox"/> Formalin <input type="checkbox"/> Michel's Media for DIF <input type="checkbox"/> Fresh Tissue <input type="checkbox"/> Alcohol			
Testing to Perform			
<input type="checkbox"/> Gross Examination & Diagnostic Interpretation <input type="checkbox"/> Other:			
– Additional Tests			
<input type="checkbox"/> FISH for Cutaneous Melanoma <i>CMFISH</i> <input type="checkbox"/> T-Cell Clonality <i>TCRB & TCRG TCBMDO</i> <input type="checkbox"/> Direct Immunofluorescence <input type="checkbox"/> B-Cell Clonality <i>IGH & IGK BCBMDO</i> <input type="checkbox"/> IHC Stain:			
Specimen B			
Collection Date	____ / ____ / ____ <small>month day year</small>	Time ____:____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Biopsy Site			
Type of Biopsy			
<input type="checkbox"/> Curettings <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Punch Excision <input type="checkbox"/> Shave Excision <input type="checkbox"/> Wide Excision			
Date in Fixative	____ / ____ / ____ <small>month day year</small>	Time ____:____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Fixative Type			
<input type="checkbox"/> Formalin <input type="checkbox"/> Michel's Media for DIF <input type="checkbox"/> Fresh Tissue <input type="checkbox"/> Alcohol			
Testing to Perform			
<input type="checkbox"/> Gross Examination & Diagnostic Interpretation <input type="checkbox"/> Other:			
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