Dermatology Requisition

We file all primary and secondary insurance plans if information is provided. Secondary insurance information on back.

INFORM DIAGNOSTICS™
A FULGENT GENETICS COMPANY

All cases are assumed Global (process and interpret). If NOT Global, please indicate: ○ Slide Process Only (TC) ○ Interpretation Only (PC)

PATIENT INFORMATION (Items in tinted boxes are required)

Date of Collection / /	Date of Birth / /	Age	Sex
Last Name			
First Name			MI
Street Address			Apt #
City	State		Zip
Patient Phone #	Patient Alternate Phone #		
Patient Social Security #	Patient Medical Record #		

BILLING INFORMATION — PRIMARY INSURED (Secondary information on back)

Insurance Carrier	Policy Number / Insured ID Number		Group Number	
Claims Address			Policy Holder's Name	
City		State	Zip	Claims Phone #
Insured's Relationship to Patient ○ Self ○ Spouse ○ Dependent	Policy Holder's DOB / /	Sex ○ M ○ F	If Uninsured Patient ○ Self Pay ○ Indigent	
Policy Holder's Address	City		State	Zip

Ordering Physician/Practioner Signature **X** _____

DERMATOPATHOLOGY TEST REQUEST (Check all that apply)

	Shave	Punch	Curette	Biopsy	Excision	Re-Excision	Left	Right	Clinical Impression / History / Prior Pathology	Specimen Labels
A	❍	❍	❍	❍	❍	❍	❍	❍		**Patient:** _____ **Site A:** _____ **Clinician:** _____
B	❍	❍	❍	❍	❍	❍	❍	❍		**Patient:** _____ **Site B:** _____ **Clinician:** _____
C	❍	❍	❍	❍	❍	❍	❍	❍		**Patient:** _____ **Site C:** _____ **Clinician:** _____
D	❍	❍	❍	❍	❍	❍	❍	❍		**Patient:** _____ **Site D:** _____ **Clinician:** _____

SPECIAL TESTS / CONSULTATION / SECOND OPINION (Continued on reverse)

❍ Consultation / Second Opinion Please include pathology report.	Immunoflourescence: ❍ Direct ❍ Indirect	In situ hybridization for HPV ❍ High Risk (16, 18, 31, 33, 34, 39, 45, 51, 52, 56, 58, and 66) ❍ Low Risk (6 and 11)
Gene rearrangement studies for cutaneous lymphoproliferative disorders ❍ T-cell receptor ❍ B-cell receptor	**Melanoma Fluorescence in situ hybridization (FISH) assay** ❍ FISH test with consultation ❍ FISH test only	**See reverse for additional tests.**

In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics only to perform testing that is medically necessary for the diagnosis and treatment of patients

1111 S. Freeport Pkwy., Coppell, TX 75019 / 866-588-3280 / Fax: 866-688-3280 / CLIA 45D0975010
4207 E. Cotton Center Blvd., Phoenix, AZ 85040 / 800-768-0958 / Fax: 866-688-3280 / CLIA 03D1064744
15 Crawford St., Suite 100, Needham, MA 02494 / 857-229-1506 / Fax: 617-969-3393 / CLIA 22D0957540

FOR LAB USE ONLY

Billing / Lab (White) Client (Yellow)

Dermatology Requisition

INFORM DIAGNOSTICS
A FULGENT GENETICS COMPANY

SPECIAL TESTS (Continued)	
Malignant Melanoma mutational analysis: ❍ BRAF ❍ Kit ❍ NRAS ❍ PTEN expression by IHC	**Other:**

BILLING INFORMATION — SECONDARY INSURED				
Insurance Carrier	Policy Number / Insured ID Number		Group Number	
Claims Address			Policy Holder's Name	
City	State		Zip	Claims Phone #
Insured's Relationship to Patient ○ Self ○ Spouse ○ Dependent	Policy Holder's DOB / /	Sex ○ M ○ F	If Uninsured Patient ○ Self Pay ○ Indigent	
Policy Holder's Address	City		State	Zip

I authorize the release of medical information related to services provided herein to my health plan / insurance carrier and authorize payment directly to:

_____

and/or other lab service provider. I assume responsibility for payment of charges not covered by my healthcare insurer.

Patient's Signature _____ Date _____