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:** _____
	Site A									
B	❍	❍	❍	❍	❍	❍	❍	❍		**Patient:** _____ **Site B:** _____ **Clinician:** _____
	Site B									
C	❍	❍	❍	❍	❍	❍	❍	❍		**Patient:** _____ **Site C:** _____ **Clinician:** _____
	Site C									
D	❍	❍	❍	❍	❍	❍	❍	❍		**Patient:** _____ **Site D:** _____ **Clinician:** _____
	Site D									

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 page 2 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

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FOR LAB USE ONLY

Billing / Lab (White) Client (Yellow)

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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 _____