Dermatopathology Requisition

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

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

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	**Immunofluorescence:** ❍ Direct ❍ Indirect	**In situ hybridization for HPV** ❍ High Risk (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58 and 66) ❍ Low Risk (6 and 11) **See reverse for additional tests.**
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	

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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INFORM™ DIAGNOSTICS

SPECIAL TESTS (Continued)

Malignant Melanoma mutational analysis:	**Other:**
❍ BRAF ❍ Kit ❍ NRAS ❍ PTEN expression by IHC	

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	Policy Holder's DOB	Sex	If Uninsured Patient
❍ Self ❍ Spouse ❍ Dependent	/ /	❍ M ❍ F	❍ 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 ____________________