ATLANTA Oral PATHOLOGY

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ORAL and MAXILLOFACIAL PATHOLOGY
OTOLARYNGOLOGIC PATHOLOGY
TEST REQUEST FORM

REQUIRED PATIENT INFORMATION

PATIENT NAME: *(please print last, first, middle)*

____

DOB: ____________ **AGE:** _____ **SEX:** ☐ **M** ☐ **F**

ADDRESS: ______________________________

CITY: _____________ **STATE:** _____ **ZIP:** _____

PHONE: ______________ **FAX:** _____________

Patient insurance information MUST be completed for ANY/ALL insurance to be filed. Attach a copy of insurance card (including Medicare and Medicaid.)

MEDICARE# ______________________________

MEDICAID# ______________________________

INSURANCE COMPANY: ____________________

POLICY# ________________________________

GROUP# _________________________________

ADDRESS: ______________________________

CITY: _____________ **STATE:** _____ **ZIP:** _____

PHONE: ______________ **FAX:** _____________

REQUIRED DOCTOR INFORMATION

SUBMITTING DOCTOR NAME: *(please print)*

____

INSTITUTION: ____________________________

DOCTOR ADDRESS: _______________________

_________________ **SUITE/ROOM:** __________

CITY: __________ **STATE:** _____ **ZIP:** _________

PHONE: ______________ **FAX:** ______________

UPIN/PROVIDER# __________________________

(Client authorization or person legally responsible for bill, if other than patient.)

RESPONSIBLE PARTY: ______________________

ADDRESS: _______________________________

CITY: _____________ **STATE:** _____ **ZIP:** _____

RELATIONSHIP: ☐**SELF** ☐**SPOUSE** ☐ **DEPENDENT**

LAB DATA: _________________________________

____

ATTENTION: All material submitted (slides, containers etc.) must be labeled with patient name and second identifier accompanied by requisition. When ordering tests in which Medicare reimbursement will be sought, physicians should ONLY order tests which are medically necessary for diagnosis or treatment.

To meet Federal Compliance Standards, ICD-9 code must be included: ICD-9 CODE: 1. _______ **2.** ______

DATE SPECIMEN TAKEN: ___________________

SIZE OF LESION: _________________________

LOCATION: ______________________________

CLINICAL HISTORY: _______________________

____

____

____

____

SPECIMEN TYPE: ☐ **INCISIONAL BIOBSY**

☐ **EXCISIONAL BIOPSY**

CLINICAL DIAGNOSIS: ______________________

____

____

RADIOGRAPH SENT: _____ **PHOTO SENT:** _____

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