ATLANTA Oral PATHOLOGY

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ORAL and MAXILLOFACIAL PATHOLOGY
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TEST REQUEST FORM

REQUIRED PATIENT INFORMATION

PATIENT NAME: *(Please print.)*

_____
Last First Middle

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

SS #: _____

ADDRESS: _____

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

PHONE: _____

Patient MEDICAL insurance information MUST be provided for ANY/ALL insurance to be filed. Please attach a copy of front & back of insurance card.

MEDICARE# _____

MEDICAID# _____

INSURANCE COMPANY: _____

POLICY# _____

GROUP#_____

ADDRESS: _____

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

PHONE: _____

REQUIRED DOCTOR INFORMATION

SUBMITTING DOCTOR'S NAME: *(Please print.)*

_____

INSTITUTION: _____

ADDRESS: _____

BLDG./SUITE: _____

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

PHONE: _____

FAX: _____

NPI # _____

GUARANTOR: _____
(Person legally responsible for bill - e.g. parent of minor child.)

DOB: _____

ADDRESS: _____

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

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

SUBSCRIBER: _____

DOB: _____

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-10 code must be included. ICD-10 CODE: 1. _____ **2.** _____

DATE SPECIMEN TAKEN: _____

SIZE OF LESION: _____

LOCATION OF BX: _____

CLINICAL HISTORY: _____

_____

_____

_____

SPECIMEN TYPE: ☐ **INCISIONAL BIOPSY**

☐ **EXCISIONAL BIOPSY**

CLINICAL DIAGNOSIS: _____

_____

_____

RADIOGRAPH SENT: _____

CLINICAL PHOTO SENT: _____

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