ATLANTA Oral PATHOLOGY

Susan Muller, DMD
Steven D. Budnick, DDS
ORAL and MAXILLOFACIAL PATHOLOGY
OTOLARYNGOLOGIC PATHOLOGY

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: _____

2701 North Decatur Road, Decatur, GA 30033 ● P: (404) 501-7445 ● F: (404) 501-6458
www.atlantaoralpathology.com

ATLANTA Oral PATHOLOGY

Your doctor has chosen to send your biopsy to **Atlanta Oral Pathology**. All of our doctors are board certified and have done additional specialty training in oral, head and neck pathology. You will receive an additional bill for our services and the following information should be helpful, as medical billing has become very complex.

We will be happy to submit the charge to your insurance company and we accept most **medical** insurance plans. Rather than a single bill, **you will receive two separate bills**, one from Emory Decatur Hospital (formerly Dekalb Medical) for the technical charges, and one from Dekalb Pathology P.C. for the professional reading of the biopsy. **Medical insurance will be submitted for both.** Once we receive the payment from the insurance carrier, you will only be responsible for any copayment or deductible. We do not bill for the balance of the charge. In the event you do not have insurance, you will be responsible for payment of the bill.

Please do not call your doctor regarding your bill. Please call the phone number on your bill and they will be able to answer any questions and resolve most problems. If your problem is not resolved, please call Atlanta Oral Pathology at (404) 501-7445 and we will do everything possible to resolve the issue.

Your doctor has chosen to use our lab as a continuing part of their quality care. Please feel free to call us with any questions.

I have read and understand the above information.

Signature: _____ **Date:** _____