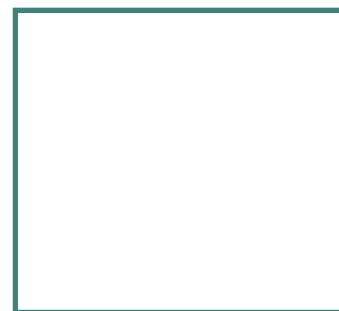


DERMATOPATHOLOGY ROUTINE AND MOLECULAR TESTING REQUISITION

EIN: 20-4506043 | CLIA: 10D1055514



Patient Information			
Last	First	MI	
DOB	SSN	<input type="checkbox"/> F	<input type="checkbox"/> M
Address			
City	State	ZIP	Phone

Physician Information	
Copy To	Fax
Copy To	Fax

Medical Record #

Billing	
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Bill Patient	
<input type="checkbox"/> Bill Insurance (Attach a copy of front & back of ID card(s) or complete below)	
Insurance Information (complete this section and/or use check boxes below)	
ICD 10 CODE:	
Name of Carrier	Phone #
Carrier Address	
Policy #	Group/Plan #
Name of Insured (if not same as patient)	
DOB of Insured	Relationship to Patient
<input type="checkbox"/> SEE ATTACHED	<input type="checkbox"/> Secondary insurance exists. Please include a second sheet.

Testing Authorization	
<i>I authorize that payment be made on my behalf to Vitro for any services furnished by them and also authorize Vitro to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to these services. If my health insurance plan will not direct payment to Vitro, I agree to forward Vitro all payments received for their services. I also authorize Vitro or any holder of medical information about me to release to my Health Insurance Plan such information needed to adjudicate their claim.</i>	
PATIENT SIGNATURE	DATE

<p>NOTICE TO ORDERING PHYSICIAN: We respectfully ask that you, the ordering physician, authenticate your order for the pathologic examination of the accompanying specimen(s) by personally signing this requisition in the space provided, or by initialing next to your printed name. If your signature (or initials) is not affixed hereto, you attest that you have caused the subject patient's medical record to include a specific reference (i.e., order) to your intent that the accompanying specimen(s) be examined by a pathologist, and that you have personally signed (handwritten or electronic) said reference (i.e., order) in the subject patient's medical record.</p>	
PHYSICIAN SIGNATURE	DATE

Specimen/Specialty Tests/Consultations			
COLLECTION DATE	<input type="checkbox"/> Special Handling (Please Specify:)	<input type="checkbox"/> B/T cell Gene Rearrangement	<input type="checkbox"/> STAT/RUSH
____/____/____	<input type="checkbox"/> Consultation / Second Opinion		
	<input type="checkbox"/> Other:		

	COLLECTION METHOD	Clinical Diagnosis
A <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave	<input type="checkbox"/> Check margins <input type="checkbox"/> DIF <input type="checkbox"/> Previous biopsy #: _____
B <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave	<input type="checkbox"/> Check margins <input type="checkbox"/> DIF <input type="checkbox"/> Previous biopsy #: _____
C <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave	<input type="checkbox"/> Check margins <input type="checkbox"/> DIF <input type="checkbox"/> Previous biopsy #: _____
D <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave	<input type="checkbox"/> Check margins <input type="checkbox"/> DIF <input type="checkbox"/> Previous biopsy #: _____
E <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave	<input type="checkbox"/> Check margins <input type="checkbox"/> DIF <input type="checkbox"/> Previous biopsy #: _____
F <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave	<input type="checkbox"/> Check margins <input type="checkbox"/> DIF <input type="checkbox"/> Previous biopsy #: _____