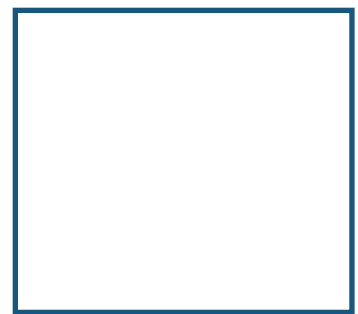




**GENERAL REQUISITION**

EIN: 20-4506043 | CLIA: 10D105514



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

Billing	
<input type="checkbox"/> Insurance	<input type="checkbox"/> Hospital non-patient
<input type="checkbox"/> Hospital in-patient	<input type="checkbox"/> Client Bill
Insurance Information (complete this section and/or use check boxes below)	
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.

Physician Information	
Copy to:	Fax:
Copy to:	Fax:

Name of Person Completing Form	Authorization #	Date Of Procedure: _____ / _____ / _____	Time of Procedure: _____ AM _____ PM	IDC-10 CODE:
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Clinical Information	

SPECIMEN SOURCE	PROCEDURE
<b>A</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____
<b>B</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____
<b>C</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____
<b>D</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____
<b>E</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____
<b>F</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____
<b>G</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____
<b>H</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____
<b>I</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____
<b>J</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____
<b>K</b>	<input type="checkbox"/> FNA <input type="checkbox"/> CORE BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISIONAL BX <input type="checkbox"/> INCISIONAL BX <input type="checkbox"/> OTHER: _____

Testing Authorization	
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.	
PATIENT SIGNATURE	DATE

**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.

PHYSICIAN SIGNATURE	DATE
MEDICAL RECORD #	