PROPATH
A Sonic Healthcare Anatomic Pathology Practice

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REFERRED BY

Complete Shaded Box For Patient And Third Party Billing

PATIENT INFORMATION - PLEASE PRINT: PATIENT NAME (LAST) (FIRST) (M.I.)

ADDRESS		APT#
CITY	STATE	ZIP
(AREA CODE) PHONE	BIRTH DATE	SEX
PATIENT S.S. #	PATIENT I.D.#	

BILL TO: ☐ **Account** ☐ **Patient (Self Pay)** ☐ **Medicare** ☐ **Medicaid** ☐ **Insurance** ***Please submit a copy of ID card (front and back)**

INSURANCE COMPANY NAME (attach card)	EMPLOYER NAME	
NAME OF INSURED	POLICY / MEMBER ID #	GROUP #

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

MAIL CLAIM TO

ADDRESS

CITY/STATE/ZIP

Referring Physician: ____________________ NPI: ____________

DATE COLLECTED

Send Duplicate Report to: ____________________
Name: ____________________
Address: ____________________
City/State/Zip: ____________________

PHYSICIAN ACKNOWLEDGEMENT (Required)

Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient. ***Medicare Patients: The Advance Beneficiary Notice, if required, must be completed, signed by the patient and attached.***

Physician's Signature: ____________________ **Date Ordered** ____________

DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

DIAGNOSIS CODE	DIAGNOSIS CODE	DIAGNOSIS CODE

ORAL AND MAXILLOFACIAL PATHOLOGY

Radiographs: ☐ Yes ☐ No ☐ Enclosed
Clinical Images: ☐ Yes ☐ No ☐ Enclosed
Email to: Paras.Patel@ProPath.com

Previous Biopsy Results ____________________

Immunofluorescence (Part ____________)

Specimen Number	Specimen Source/Site	DIagnosis / Comments	Margins Requested	Specimen Type
A (1)			☐	☐ Incisional ☐ Excisional
B (2)			☐	☐ Incisional ☐ Excisional
C (3)			☐	☐ Incisional ☐ Excisional
D (4)			☐	☐ Incisional ☐ Excisional

PROVISIONAL DIAGNOSIS:

CASE HISTORY / DESCRIPTION:

Please include the diagnosis code(s) at the highest level of specificity as documented in the patient medical record for this requisition date of service.