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REFERRED BY

PROPATH
A Sonic Healthcare Anatomic Pathology Practice

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MEDICARE PATIENTS ONLY
Must complete Advance Beneficiary Notice (ABN) on back of the first copy of this requisition

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.#

Complete Shaded Box For Patient And Third Party Billing

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: _____

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

DIAGNOSIS CODE | DIAGNOSIS CODE | DIAGNOSIS CODE

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:** _____

DERMATOPATHOLOGY REQUISITION

PREVIOUS BIOPSY NUMBER: _____ PREVIOUS BIOPSY RESULTS: _____ IMMUNOFLOURESCENCE (PART _____)

SPECIMEN NUMBER		SPECIMEN SOURCE/SITE	PRE/POST-OP DIAGNOSIS / COMMENTS	MARGINS REQUESTED	SPECIMEN TYPE*
A (1)	Name A			☐	Bx: ☐ Sh ☐ Cur ☐ Pn Ex: ☐ Sh ☐ Elp ☐ Pn
B (2)	Name B			☐	Bx: ☐ Sh ☐ Cur ☐ Pn Ex: ☐ Sh ☐ Elp ☐ Pn
C (3)	Name C			☐	Bx: ☐ Sh ☐ Cur ☐ Pn Ex: ☐ Sh ☐ Elp ☐ Pn
D (4)	Name D			☐	Bx: ☐ Sh ☐ Cur ☐ Pn Ex: ☐ Sh ☐ Elp ☐ Pn
E (5)	Name E			☐	Bx: ☐ Sh ☐ Cur ☐ Pn Ex: ☐ Sh ☐ Elp ☐ Pn
F (6)	Name F			☐	Bx: ☐ Sh ☐ Cur ☐ Pn Ex: ☐ Sh ☐ Elp ☐ Pn
G (7)	Name G			☐	Bx: ☐ Sh ☐ Cur ☐ Pn Ex: ☐ Sh ☐ Elp ☐ Pn
H (8)	Name H			☐	Bx: ☐ Sh ☐ Cur ☐ Pn Ex: ☐ Sh ☐ Elp ☐ Pn

Microbiology Culture Source: _____ ☐ Aerobic culture reflex to sensitivity ☐ Anaerobic culture ☐ Fungal culture ☐ Mycobacteria culture ☐ Gram stain v12/22

Clinical History/Impression/Additional Testing: _____ *SPECIMEN TYPE: Bx - Biopsy Sh - Shave Pn - Punch Ex - Excision Elp - Ellipse Cur - Curettage

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.