SURGICAL PATHOLOGY REQUEST FORM

(PATIENT IDENTIFICATION)

▶ ***PLEASE FURNISH COMPLETE PATIENT DATA*** ◀

Specimens Will Not Be Accepted by the Laboratory Until All Required Fields Are Completed

PATIENT NAME REQUIRED — LAST / FIRST / MI				HOME ADDRESS		
STATE	ZIP CODE	HOME PHONE NO.	WORK PHONE NO.	SEX REQUIRED	BIRTHDATE: (M/D/Y) REQUIRED	RACE
PATIENT'S SOCIAL SECURITY NO.		MEDICAL RECORD NO.		FINANCIAL NO.		
REQUESTING PHYSICIAN (*FULL NAME*) REQUIRED — FIRST / LAST			SERVICE/SPECIALTY	PATHOLOGY NO.		
DATE OF SERVICE	**PATHOLOGY DEPARTMENT USE ONLY**	ICD-9-CM	SERVICE CODES			

TO BE COMPLETED BY REQUESTING PHYSICIAN

SPECIMENS SUBMITTED REQUIRED ______________________________

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PERTINENT HISTORY, PHYSICAL FINDINGS, LABORATORY DATA (including OB-Gyn) ______________________________

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PROCEDURE PERFORMED

CLINICAL DIAGNOSIS

SURGICAL PATHOLOGY REQUEST FORM

(PATIENT IDENTIFICATION)

▶ *PLEASE FURNISH COMPLETE PATIENT DATA* ◀

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PATIENT NAME — REQUIRED — LAST — FIRST — MI

HOME ADDRESS

STATE | ZIP CODE | HOME PHONE NO. | WORK PHONE NO. | SEX (REQUIRED) | BIRTHDATE: (M/D/Y) (REQUIRED) | RACE

PATIENT'S SOCIAL SECURITY NO. | MEDICAL RECORD NO. | FINANCIAL NO.

REQUESTING PHYSICIAN (*FULL NAME*) — REQUIRED — FIRST — LAST | SERVICE/SPECIALTY | PATHOLOGY NO.

DATE OF SERVICE | **PATHOLOGY DEPARTMENT USE ONLY** | ICD-9-CM | SERVICE CODES

TO BE COMPLETED BY REQUESTING PHYSICIAN

SPECIMENS SUBMITTED REQUIRED

PERTINENT HISTORY, PHYSICAL FINDINGS, LABORATORY DATA (Including OB-Gyn)

PROCEDURE PERFORMED

CLINICAL DIAGNOSIS

▼ TO BE COMPLETED FOR SPECIMENS FROM PHYSICIAN'S OFFICES ▼ TO BE COMPLETED BY PATIENT FOR BILLING

THE RESPONSIBLE PARTY IS THE PERSON WHO IS THE POLICYHOLDER OF THE HEALTH INSURANCE
IF THE PATIENT IS THE RESPONSIBLE PARTY, CHECK HERE ☐ THEN CONTINUE TO HEALTH INSURANCE INFORMATION

RESPONSIBLE PARTY'S NAME: (*LAST, FIRST MIDDLE*) | PATIENT RELATION TO RESPONSIBLE PARTY: 2 ☐ SPOUSE 3 ☐ CHILD 4 ☐ OTHER

HOME ADDRESS: | APT. NO./P.O. BOX:

CITY: | STATE: | ZIP CODE: | HOME TELEPHONE: ( ) | WORK TELEPHONE: ( )

RESPONSIBLE PARTY'S OCCUPATION | EMPLOYER: | WORK ADDRESS:

HEALTH INSURANCE INFORMATION

BLUE SHIELD OF D.C. (MEDICAL SERVICE OF D.C.) — FED.	IDENTIFICATION NO. R	ENROLLMENT CODE	EFFECTIVE DATE	MEDICARE	HEALTH INSURANCE CLAIM NO.	MED. INS.(PART B) EFFECTIVE DATE
NON FED.	IDENTIFICATION NO.	GROUP NO.	SVC. CODE OR BSPI	EFFECTIVE DATE	D.C. MEDICAID	D.C. IDENTIFICATION NO. (DCID)	DATES ON CARD
OTHER INSURANCE	NAME OF INSURANCE COMPANY		POLICY HOLDER'S NAME		OTHER MEDICAID	☐ MD ☐ VA — IDENTIFICATION NO.	DATES ON CARD
	POLICY NO.	GROUP NO. OR NAME	EFFECTIVE DATE	INSURANCE CO. ADDRESS			
SELF-PAY	☐ YES	FOR OFFICE USE ONLY — INSURANCE CODE 1	INSURANCE CODE 2		INSURANCE CODE 3		REGISTERED BY/DATE

THE UNIVERSITY HOSPITAL DIVISION OF ANATOMIC PATHOLOGY

PATIENT AUTHORIZATION FORM

I give permission to my insurance provider(s) including Medicare and Medicaid, to pay the for my anatomic pathology service instead of paying me. I understand that I will have to pay what my insurance does not cover or pay.

I certify that the information I have reported is correct and further authorize the release of information needed to pay benefits for this service. Information may be released to my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in the place of the original.

PATIENT ____________ / ____________ **(SEAL)**
PRINT NAME — SIGNATURE — DATE

RESPONSIBLE PARTY ____________ / ____________ ____________ **(SEAL)**
PRINT NAME — SIGNATURE — DATE