DERMPATH DIAGNOSTICS®
INDIANA

DERMATOPATHOLOGY REQUISITION

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.

STREET ADDRESS	APT. #

CITY	STATE	ZIP CODE

PATIENT PHONE NUMBER	PATIENT SOCIAL SECURITY NUMBER

DATE OF BIRTH / /	AGE	SEX	PATIENT ID

PHYSICIAN/CLIENT INFORMATION

BILLING/INSURANCE INFORMATION (Attach a copy of insurance card-both sides)

BILL:

- ☐ INSURANCE
- ☐ PATIENT
- ☐ MEDICARE
- ☐ MEDICAID
- ☐ PHYSICIAN
- ☐ INPATIENT
- ☐ OUTPATIENT
- ☐ EMER. ROOM

SUBSCRIBER PRIMARY INSURANCE

SUBSCRIBER NAME / RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent

COMPANY NAME

ADDRESS

CITY	STATE	ZIP CODE

EMPLOYER NAME

SUBSCRIBER DOB: / /	GROUP/CONTRACT #	MEMBER ID#

SUBSCRIBER SEX: ☐ Male ☐ Female	MEDICARE #	MEDICAID ID#

SUBSCRIBER SECONDARY INSURANCE

SUBSCRIBER NAME / RELATIONSHIP TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent

COMPANY NAME

ADDRESS

CITY	STATE	ZIP CODE

EMPLOYER NAME

SUBSCRIBER DOB: / /	GROUP/CONTRACT #	MEMBER ID#

SUBSCRIBER SEX: ☐ Male ☐ Female	MEDICARE #	MEDICAID ID#

SEND DUPLICATE REPORT TO: ADDRESS / FAX:

DATE COLLECTED: ____/____/____ ☐ IMMUNOFLUORESCENCE ☐ SLIDE PREP ONLY

CLINICAL INFORMATION

SITE	CHECK:	MARGINS?	CLINICAL DIAGNOSIS AND HISTORY
A	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
B	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
C	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
D	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
E	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
F	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	

PHYSICIAN'S SIGNATURE (Required in NY, NJ, MA and PA) X _____ **DATE** _____

FOR LAB USE ONLY

ICD-9 Codes:

In some cases, additional diagnostic stains may be required for proper evaluation as deemed appropriate by the Dermpath Diagnostics Dermatopathologist. These additional tests will result in additional charges.