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## DERMATOPATHOLOGY REQUISITION

AMERIPARI CLEVELAND	IMMUNOFLUORESCEN	CE 🗌 RUSH			
PATIENT INFORMATION			CLIENT INFORMATION		
ast Name First Name		M.I.			
Street Address	/	Apt. #			
City	State 2	Zip			
Patient Phone Number Patient Soc	ial Security Number				
Date of Birth Age Sex Patient ID					
BILLING/INSURANCE (Attach copy of in	surance card - bot	th sides)			
Subscriber Insurance         Secondary           Insurance         Subscriber Name / Relationship to Subscriber	Insurance Informatio	Dependent			
] Medicare					
Medicaid Company Name					
Worker's Address					
Comp Address					
Physician City	State Zi	ip	Treating Physician	NPI # (required)	UPIN #
] Hospital			Physician's	Required for	or NY, NJ, MA and WV
	Member ID#	l	Signature X Send duplicate of report to:		
Ion-hospital / /					
Hospital Subscriber Sex: Medicare#	Medicaid ID#		Name		
II / OT / EII/			Address/Fax		
CLINICAL INFORMATION	CHECK:	MARGINS?	CLINICAL DIAGNOSIS AND HISTORY		
SHE		MANGING:	CLINICAL DIAGNOSIS AND HISTORY		
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER				
B	SHAVE  PUNCH  EXCISION  OTHER				
С	SHAVE  PUNCH  EXCISION  OTHER				
D	SHAVE  PUNCH  EXCISION  OTHER				
E	SHAVE  PUNCH  EXCISION  OTHER				
F	SHAVE  PUNCH  EXCISION  OTHER				
Date Collected: / Time:			By:		
FOR LAB USE ONLY					ICD Codes:
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PATIENT INFORMATION			CLIENT INFORMATION		
ast Name First Name		M.I.			
Street Address	/	Apt. #			
City	State 2	Zip			
Patient Phone Number Patient Soc	ial Security Number				
Date of Birth Age Sex Patient ID					
BILLING/INSURANCE (Attach copy of in	surance card - bot	th sides)			
Subscriber Insurance         Secondary           Insurance         Subscriber Name / Relationship to Subscriber	Insurance Informatio	Dependent			
] Medicare					
Medicaid Company Name					
Worker's Address					
Comp Address					
Physician City	State Zi	ip	Treating Physician	NPI # (required)	UPIN #
] Hospital			Physician's	Required for	or NY, NJ, MA and WV
	Member ID#	l	Signature X Send duplicate of report to:		
Ion-hospital / /					
Hospital Subscriber Sex: Medicare#	Medicaid ID#		Name		
II / OT / EII/			Address/Fax		
CLINICAL INFORMATION	CHECK:	MARGINS?	CLINICAL DIAGNOSIS AND HISTORY		
SHE		MANGING:	CLINICAL DIAGNOSIS AND HISTORY		
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER				
B	SHAVE  PUNCH  EXCISION  OTHER				
С	SHAVE  PUNCH  EXCISION  OTHER				
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Date Collected: / Time:			By:		
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	INFORM	ATION				CLIENT INFORMATION		
Last Name			First Nam	е	M.I.			
Street Addres	s		I		Apt. #			
City				State	Zip			
Patient Phone	Number		Patient So	ocial Security Numbe	r			
Date of Birth / /	Age	Sex	Patient ID					
BILLING/	INSURAN	CE (At	tach copy of i	nsurance card - b	oth sides)			
Bill:	Subscriber	nsuran	ce 🗌 Secondary	/ Insurance Informa	ion Attached			
<ul> <li>Insurance</li> <li>Medicare</li> </ul>	Subscriber Nam	e / Relatio	onship to Subscribe	er 🗌 Self 🗌 Spouse	Dependent			
Medical	Company Name							
Worker's								
Comp	Address							
Patient Physician	City			State	Zip	Treating Physician	NPI # (required)	UPIN #
Hospital	Employer Name					Physician's	Required f	I or NY, NJ, MA and WV
Outpatient/	Subscriber DOB	: Group	/Contract #	Member ID#		Signature X Send duplicate of report to:		
Non-hospital	1 1					Name		
Hospital	Subscriber Sex:		are#	Medicaid ID#				
(IP/OP/ER)						Address/Fax		
SITE	LINFORM	AHON		CHECK:	MARGINS?	CLINICAL DIAGNOSIS AND HISTORY		
В				SHAVE PUNCH EXCISION OTHER				
С				SHAVE PUNCH EXCISION OTHER				
D				SHAVE PUNCH EXCISION OTHER				
Ε				SHAVE PUNCH EXCISION OTHER				
F				SHAVE PUNCH EXCISION OTHER				
Date Collected	d: / /	т	īme:			By:		
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These offerings	may require sp	ecial stud	lies, markers or s	stains as deemed app	opriate for prope	er evaluation by AmeriPath pathologist. These add	itional tests may result	in additional charges

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