

6918 Camp Bullis Rd. San Antonio, TX 78256 www.corepath.us **P** 1.877.617.4445 | **F** 210.617.4457

REQUIR	EED ITEMS		
1. CBC		y of the Pa	atient's Insurance Card and Demographic Information) 5. Provider's Signature
PATIENT INFORMATION PROVIDER INFORMATION			
Last Name			
First Nam	ne M.I		
DOB			
Address		Authori	ized Provider Signature Date
City	State Zip	Please	Fax Duplicate Report to Additional Provider Fax
Phone _	Patient ID		
BILLING INFORMATION			
Bill to: Insurance Medicare Referring Facility (Hospital/Client) Split Billing - Client (TC) and Insurance (PC) Patient			
Patient Status: Inpatient (Hospital) Outpatient (Hospital) Non-Hospital ASC Prior Authorization #			
CLINICAL INFORMATION			
Indication(s) for Testing:			
CD-10 Codes: Disease: New Diagnosis Refractory Recurrent/Relapsed Follow-Up			
PRE-OP DIAGNOSIS POST-OP DIAGNOSIS			
SPECIMEN INFORMATION			
Date Collected/			
Time Placed in Formalin (Breast Only) : AM PM Biopsy Culture Punch Shave FNA Submitted Fresh Curettage Excision			
Date Retrieved// Cytology Other:			
Specimen ID			
SPECIM	EN SITES (FOR MORE TESTING INFORMATION, VISIT COREPATH.US)		
A		н	
В			
С		J	
D		К	
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F	RATORY USE ONLY	М	