

REQUIRED ITEMS

1. Clinical Information 2. ICD 10 Codes 3. Face Sheet (Front and Back Copy of the Patient's Insurance Card and Demographic Information) 4. Provider's Signature

PATIENT INFORMATION

Last Name _____
 First Name _____ M.I. _____
 DOB: MM / DD / YYYY Gender: Male Female Other _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Patient ID _____

PROVIDER INFORMATION

Authorized Provider Signature _____ Date: MM DD YYYY
 Please Fax Duplicate Report to Additional Provider _____ Fax

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: _____

 ICD-10 Codes: _____

SPECIMEN INFORMATION

Date Collected: MM / DD / YYYY Specimen ID _____

SPECIAL INSTRUCTIONS

SAMPLE LOCATION/PERTINENT HISTORY/CLINICAL DIAGNOSIS

FOR MORE TESTING INFORMATION, VISIT COREPATH.US

Specimen Type	Specimen Information	Specimen Type	Specimen Information
A/1 <input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Shave Removal <input type="checkbox"/> Include Margins in Report <input type="checkbox"/> Other: _____	Clinical Diagnosis _____ Site of Removal _____ Time Out of Body _____ Time in Formalin _____	E/5 <input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Shave Removal <input type="checkbox"/> Include Margins in Report <input type="checkbox"/> Other: _____	Clinical Diagnosis _____ Site of Removal _____ Time Out of Body _____ Time in Formalin _____
B/2 <input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Shave Removal <input type="checkbox"/> Include Margins in Report <input type="checkbox"/> Other: _____	Clinical Diagnosis _____ Site of Removal _____ Time Out of Body _____ Time in Formalin _____	F/6 <input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Shave Removal <input type="checkbox"/> Include Margins in Report <input type="checkbox"/> Other: _____	Clinical Diagnosis _____ Site of Removal _____ Time Out of Body _____ Time in Formalin _____
C/3 <input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Shave Removal <input type="checkbox"/> Include Margins in Report <input type="checkbox"/> Other: _____	Clinical Diagnosis _____ Site of Removal _____ Time Out of Body _____ Time in Formalin _____	G/7 <input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Shave Removal <input type="checkbox"/> Include Margins in Report <input type="checkbox"/> Other: _____	Clinical Diagnosis _____ Site of Removal _____ Time Out of Body _____ Time in Formalin _____
D/4 <input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Shave Removal <input type="checkbox"/> Include Margins in Report <input type="checkbox"/> Other: _____	Clinical Diagnosis _____ Site of Removal _____ Time Out of Body _____ Time in Formalin _____	H/8 <input type="checkbox"/> Punch <input type="checkbox"/> Excision <input type="checkbox"/> Curettage <input type="checkbox"/> Shave Biopsy <input type="checkbox"/> Shave Removal <input type="checkbox"/> Include Margins in Report <input type="checkbox"/> Other: _____	Clinical Diagnosis _____ Site of Removal _____ Time Out of Body _____ Time in Formalin _____

LABORATORY USE ONLY
