TEL # 1-888-"ACUPATH" (228-7284)
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FAX # (516) 326-3452
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WWW.ACUPATH.COM
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GENERAL SURGERY PATHOLOGY TISSUE PROCESSING REQUEST FORM

GS001

ANY OMISSION MAY RESULT IN DELAY OF REPORT

NOT FOR PATIENT USE

DUPLICATE REPORT TO: ____________________

COMMENTS TO PRINT OUT ON REPORT: ____________________

CHECK MARGINS ☐
STAT ☐
CALL MD W/RESULTS ☐
CONSULTATION ☐

PREV BX ____
DATE OBTAINED: ___/___/___
 # OF BOTTLES ____

TEST REQUEST: HISTOPATHOLOGY

- ☐ INCLUDES SPECIAL (BILLABLE) STAINS DETERMINED BY PATHOLOGIST
- ☐ PHYSICIAN MUST BE CONTACTED PRIOR TO PERFORMANCE OF SPECIAL (BILLABLE) STAINS
- ☐ CYTOLOGY FLUID   NUMBER OF SLIDES

BIOPSY SITE	FNA	DURATION/HISTORY/DESCRIBE	CLINICAL DIAGNOSIS
A			
B			
C			
D			

I authorize the release to my insurance carrier of any medical information necessary to process this claim, and I authorize payment of medical benefits directly to ACUPATH Laboratories Inc.
I also authorize release of my pathology results to my doctor utilizing all methods of transmission according to HIPAA regulations.

Patient Signature:

PATIENT INFORMATION

RACE (optional)

SS # ___-__-____   DATE OF BIRTH ___/___/___   M ☐ F ☐

LAST NAME   FIRST NAME   M.I.

STREET ADDRESS

CITY   STATE   ZIP

TEL. #   CHART / A/C #

PATIENT'S PRIMARY INSURANCE   BILL TO MC ☐   BILL TO PT ☐

INSURED'S NAME ____________________ D.O.B. ___/___/___

PT RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

POLICY # / ____________________ / SS # ____________________

GROUP NAME / # ____________________ **/Referral #** ____________________

NAME OF INSURANCE CO. ____________________

INSURANCE ADDRESS* ____________________

CITY ____________________ STATE ________ ZIP ________

* If previous biopsy on file with Acupath and same insurance company, please check box ☐

SECONDARY INSURANCE

INSURED'S NAME ____________________

PT RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

POLICY # / ____________________ / SS # ____________________

GROUP NAME / # ____________________

NAME OF INSURANCE CO. ____________________

INSURANCE ADDRESS* ____________________

CITY ____________________ STATE ________ ZIP ________

* If previous biopsy on file with Acupath and same insurance company, please check box ☐

CLINICAL DATA:

PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD OR FILL OUT INSURANCE SECTION