ACUPATH
LABORATORIES, INC

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WWW.ACUPATH.COM
"FOR THE ABSOLUTE HIGHEST STANDARD IN OPHTHALMIC PATHOLOGY" © 2019

OPHTHALMIC PATHOLOGY
TEST REQUEST FORM
OP001L

**ANY OMISSION MAY RESULT
IN DELAY OF REPORT**

PATIENT INFORMATION   RACE (optional)

M ☐
F ☐

SS#   DATE OF BIRTH

LAST NAME   FIRST NAME   M.I.

STREET ADDRESS

CITY   STATE   ZIP

TEL. #   CHART #   PATH #

☐ **TC**   ☐ **GLOBAL**

PHYSICIAN SIGNATURE_____

DUPLICATE REPORT TO:_____

COMMENTS TO PRINT OUT ON REPORT:_____

CHECK MARGINS   ☐   **DATE OBTAINED**___/___/___
STAT   ☐   OTHER_____
CALL MD W/RESULTS ☐   CONSULTATION ☐

ICD-10 CODES

TEST REQUEST:
☐ NUMBER OF SPECIMEN BOTTLES_____

BIOPSY SITE	RPMI FLOW	DURATION / HISTORY / CLINICAL DIAGNOSIS
☐ *Perform Cytospin if necessary*		
A		
B		
C		
D		

SOURCE   TEST TYPE
_____   ☐ Bacterial
_____   ☐ Culture & Sensitivity
_____   ☐ Other:_____

CLINICAL DATA (Required)_____

PATIENT'S PRIMARY INSURANCE
BILL TO: ☐ **MEDICARE** ☐ **PATIENT** ☐ **OTHER** ☐ **NO FAULT** ☐ **WORKERS COMP**

INSURED'S NAME_____ D.O.B.___/___/___

DATE OF ACCIDENT (IF NO FAULT/WORKERS COMP)___/___/___

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

POLICY #_____ SS #_____

GROUP NAME/#_____

NAME OF INSURANCE CO._____

INSURANCE ADDRESS*_____

CITY_____ STATE_____ ZIP_____

SECONDARY INSURANCE
INSURED'S NAME_____ D.O.B.___/___/___

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

POLICY #_____ SS #_____

GROUP NAME/#_____

NAME OF INSURANCE CO._____

INSURANCE ADDRESS*_____

CITY_____ STATE_____ ZIP_____

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 understand that if I do not have insurance I will be billed directly by 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_____

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

FOR LAB USE ONLY:

AFFIXED LABEL

Remove labels and affix to specimen bottles and bag.
(1 label per bottle, 1 label for bag)
V102019

☐ R ☐ L (125)
☐ R ☐ L (127)
☐ R ☐ L (126)
(128) R L (129)
(130) R L (131)

AFFIXED LABEL

LABORATORY COPY