ACUPATH LABORATORIES, INC
TEL # 1-888-"ACUPATH" (228-7284)
TEL # (516) 775-8103
FAX # (516) 326-3452
28 S. TERMINAL DRIVE, PLAINVIEW, NY 11803
WWW.ACUPATH.COM
"FOR THE ABSOLUTE HIGHEST STANDARDS"© 2007

GENERAL SURGERY PATHOLOGY TISSUE PROCESSING REQUEST FORM

GS001

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 / A/C #

DUPLICATE REPORT TO: _____

COMMENTS TO PRINT OUT ON REPORT: _____

CHECK MARGINS ☐ PREV BX

STAT ☐ **DATE OBTAINED:** ___/___/___

CALL MD W/RESULTS ☐

CONSULTATION ☐ **# 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'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. _____

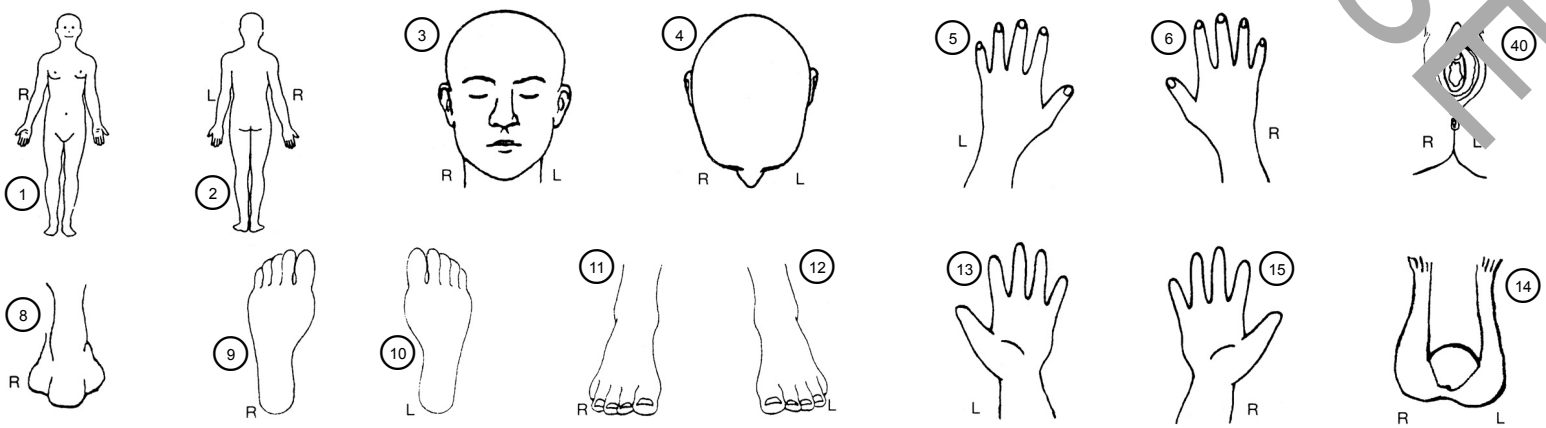
INSURANCE ADDRESS* _____

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



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