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

OPHTHALMIC PATHOLOGY TEST REQUEST FORM

OP001L

ANY OMISSION MAY RESULT IN DELAY OF REPORT

☐ 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 INFORMATION RACE (optional)

SS# ___ ___ ___ + ___ ___ + ___ ___ ___ ___ DATE OF BIRTH __/__/__ M ☐ F ☐

LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TEL. # _____ CHART # _____ PATH # _____

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_____

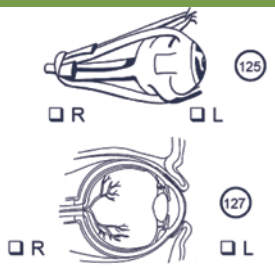
I authorize the release to my insurance carrier of any medical information necessary to process this claim, and I authorize payment of medical benefits directly to Acupath Laboratories, Inc. I understand that if I do not have insurance I will be billed directly by Acupath Laboratories, Inc.

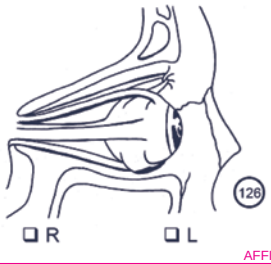
I also authorize release of my pathology results to my doctor utilizing all methods of transmission according to HIPAA regulations.

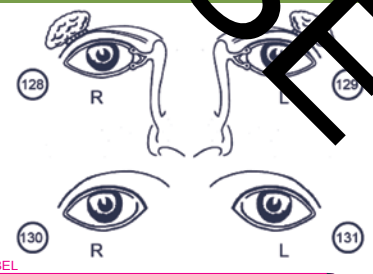
Patient Signature_____

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

LABORATORY COPY

AFFIXED LABEL