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 STANDARD" © 2020

ORAL MAXILLOFACIAL SURGERY TEST REQUEST FORM

OS001L

ANY OMISSION MAY RESULT IN DELAY OF REPORT

NOT FOR PATIENT USE

☐ 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

BIOPSY METHOD: ☐ PUNCH ☐ EXCISION ☐ INCISIONAL ☐ BRUSH

Other: _____

TEST REQUEST: HISTOPATHOLOGY

- ☐ INCLUDES SPECIAL (BILLABLE) STAINS DETERMINED BY PATHOLOGIST
- ☐ PHYSICIAN MUST BE CONTACTED PRIOR TO PERFORMANCE OF SPECIAL (BILLABLE) STAINS
- ☐ PREVIOUS BIOPSY
- ☐ NO. OF SPECIMEN BOTTLES_____ SLIDES_____ BLOCKS_____

☐ HPV - TISSUE If Screen +, do Subtype (6/11, 16/18, 31/33)

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

PATIENT INFORMATION RACE (optional)

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

LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TEL. # _____ CHART # _____ PATH # _____

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

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.___/___/___

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_____

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.

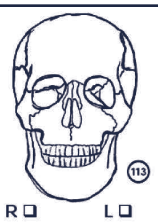
I also authorize release of my pathology results to my doctor using all methods of transmission according to HIPAA regulations.

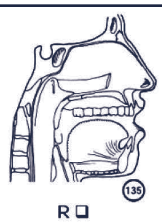
Patient Signature_____

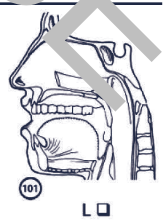
CLINICAL DATA (Required)

_____

_____







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