

Collection Date	Clinician	Additional Clinician (s)	Office Location
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<b>P A T I E N T</b>	*Name (Last) _____ (First) _____ (MI) _____ PT ID # _____		
	*SSN _____ *Date of Birth _____ *Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
	Patient Address _____		Phone _____
	City _____		State _____ Zip _____

SPECIMEN(S)	REQUIRED CLINICAL HISTORY/IMPRESSION
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1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____	1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____
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Complete Insurance Information Below	DX codes:
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<p style="text-align:center;"><b>PRIMARY INSURANCE</b></p> Member ID# / Policy # _____ Employer _____ Group # _____ Insured's Name _____ Relationship to Patient _____ Insured's SSN _____ Insured's DOB _____ Insurance Co. _____ Claims Address _____ City, ST Zip _____ <small>PLEASE ATTACH COPY OF INSURANCE CARD IF POSSIBLE</small>	<p style="text-align:center;"><b>SECONDARY INSURANCE</b></p> Member ID# / Policy # _____ Employer _____ Group # _____ Insured's Name _____ Relationship to Patient _____ Insured's SSN _____ Insured's DOB _____ Insurance Co. _____ Claims Address _____ City, ST Zip _____ <small>PLEASE ATTACH COPY OF INSURANCE CARD IF POSSIBLE.</small>
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<b>F O R S E P U S E</b>	88300 _____ CPT Level I	88311 _____ Decalcification	88305 _____ Cell Block
	88302 _____ CPT Level II	88312 _____ Organism Stain	88104 _____ Smear, non GYN
	88304 _____ CPT Level III	88313 _____ Other Special Stain	88112 _____ ThinPrep non-GYN
	88305 _____ CPT Level IV	88342 _____ IHC Stain Manual	88173 _____ Fine Needle Aspirate Interp
	88307 _____ CPT Level V	88360 _____ IHC Manual Qnt or Semiqnt	88160 _____ Cytosmear TouchPrep SI
	88309 _____ CPT Level VI	88361 _____ IHC Stain VIAS	88161 _____ Cytosmear TouchPrep PSI
	88321 _____ Consult on Ref Slides	85060 _____ Peripheral Smear Path Interp	3260F _____

Additional testing may be performed if determined medically necessary to render a diagnosis in the opinion of the reviewing pathologist.	<b>C A S E #</b>
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