

Patient Information			
Patient Name (Last)	(First)	Date Of Birth	
Referring Facility MRN	Sex M F	Patient's Phone Number ( )	
Patient Address	City	State	Zip Code

**BILL TO:**  
 Patient  PPO  HMO\*  Client  Medicare  
 Outpatient  Inpatient  
 HMO Insurance Authorization # \_\_\_\_\_  
 \*Referring facility is responsible for obtaining HMO authorization. If claim is denied due to lack of authorization, the referring facility will be billed for services.  
**Insurance Info: Attach a copy of front & back of Insurance card or face sheet.**  
 Technical (lab) and professional (M.D.) charges are billed separately.

Requestor Information	
Practice Name & Address	
Phone No.	Fax No.

**For Lab Use Only** Medicare will only pay for services that are reasonable and necessary for the diagnosis and treatment of the patient. The physician must specify an ICD code to indicate the medical necessity of each test requested.

**SPECIMEN LABELS**

Patient Name (Last, First)	DOB: _____	Site: _____
0000000000	Date: _____	
Patient Name (Last, First)	DOB: _____	Site: _____
0000000000	Date: _____	
Patient Name (Last, First)	DOB: _____	Site: _____
0000000000	Date: _____	

Requesting Physician		
Physician Name	Date	Physician NPI #:
<b>Physician Signature - REQUIRED</b> _____		

**COPIES TO:** \_\_\_\_\_  
(Name & Address, Fax & Phone)

**SPECIMEN INFORMATION**

**CLINICAL INFORMATION (Use extra sheets if more than 3 specimens)**

**SPECIMEN A:**

Alopecia Biopsy  
 Lesional Biopsy  
 Perilesional Biopsy  
 Direct Immunofluorescent Stain/Stains (DIF)  
 Indirect Immunofluorescent Stain/Stains (IIF)  
 Electron Microscopy (EM)  
 Send Duplicate Slide

Site / Slide Number: \_\_\_\_\_ Collection Date: \_\_\_\_\_

Clinical Findings: \_\_\_\_\_

SIZE: \_\_\_\_\_  
 CLINICAL DDX: \_\_\_\_\_

Clinical Photos:  
 Enclosed with Specimen  
 Sent Digitally  
 ICD Code(s):  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_

**SPECIMEN B:**

Alopecia Biopsy  
 Lesional Biopsy  
 Perilesional Biopsy  
 Direct Immunofluorescent Stain/Stains (DIF)  
 Indirect Immunofluorescent Stain/Stains (IIF)  
 Electron Microscopy (EM)  
 Send Duplicate Slide

Site / Slide Number: \_\_\_\_\_ Collection Date: \_\_\_\_\_

Clinical Findings: \_\_\_\_\_

SIZE: \_\_\_\_\_  
 CLINICAL DDX: \_\_\_\_\_

Clinical Photos:  
 Enclosed with Specimen  
 Sent Digitally  
 ICD Code(s):  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_

**SPECIMEN C:**

Alopecia Biopsy  
 Lesional Biopsy  
 Perilesional Biopsy  
 Direct Immunofluorescent Stain/Stains (DIF)  
 Indirect Immunofluorescent Stain/Stains (IIF)  
 Electron Microscopy (EM)  
 Send Duplicate Slide

Site / Slide Number: \_\_\_\_\_ Collection Date: \_\_\_\_\_

Clinical Findings: \_\_\_\_\_

SIZE: \_\_\_\_\_  
 CLINICAL DDX: \_\_\_\_\_

Clinical Photos:  
 Enclosed with Specimen  
 Sent Digitally  
 ICD Code(s):  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_