Stanford HEALTH CARE
STANFORD MEDICINE

Dermatopathology

300 Pasteur Drive, Room H2110 • Stanford, CA 94305-5624
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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 #:

Physician Signature - REQUIRED ________________________________

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. ____________

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**______________below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**____________below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____________listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____________listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**______________listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**____________listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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