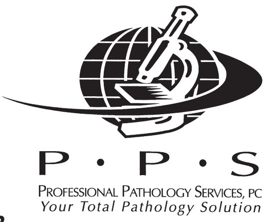


REFERRED BY

Complete The Information in the Green Shaded Box for Patient and Third Party Billing Only

SOCIAL SECURITY #

PATIENT NAME (LAST) (FIRST) (MI)

STREET

CITY STATE ZIP

SEX | DATE OF BIRTH MO. / DAY / YEAR | CHART #

PATIENT PHONE # ( ) | PATIENT HISTORY #

PLEASE INCLUDE A COPY OF INSURANCE CARD(S).

☐ MEDICARE # ______

☐ MEDICAID # ______ STATE ______

INSURANCE COMPANY ______

POLICY / I.D. # | GROUP # | EMPLOYER #

EMPLOYER NAME ______

RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ DEPENDENT

DX #1 ______ CODE ______

DX #2 ______ CODE ______

NAME OF INSURED (if different from patient)

NAME (LAST) ______ (FIRST) ______

ADDRESS ______

CITY ______ STATE ______ ZIP ______

REQUESTING PHYSICIAN

PHYSICIAN SIGNATURE/INIT. ______

Collection Date ______ *Time* ______

☐ ROUTINE ☐ RUSH CALL # ______ ☐ FAX # ______

Send Duplicate Report to: ______

Accession No./Date ______

Registration No. ______

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to Richland Pathology, LLP.

Signature ______ Date ______

TISSUE SOURCE (Please list separately)

A. ______

B. ______

C. ______

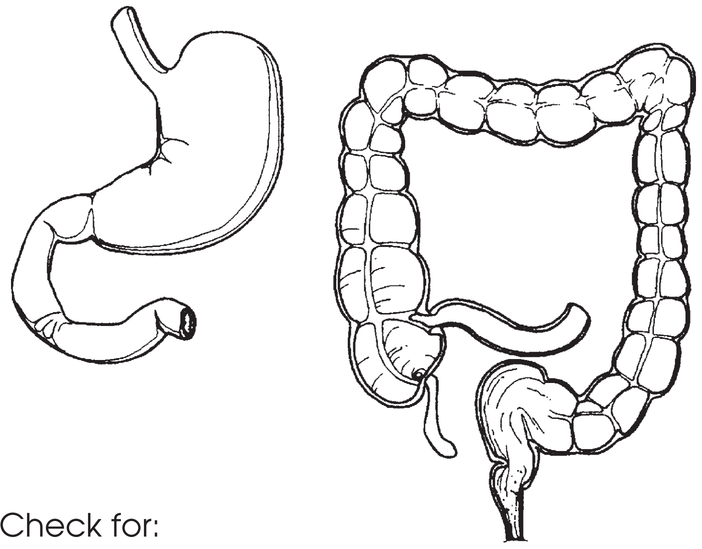
D. ______

E. ______

F. ______

G. ______

CLINICAL DATA



Check for:

☐ CLO-test

☐ Cytology