

Required Information is Highlighted

CellNetix Pathology & Laboratories



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 01-07-2022

Patient Information				Specimen Information		
PATIENT LAST NAME	FIRST	M.I.	BIRTH SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	GENDER ID <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	COLLECTION DATE	TIME
PATIENT D.O.B.	PATIENT SOCIAL SECURITY NUMBER	PHONE	RACE/ETHNICITY		ICD-10 CODE(S)	
STREET ADDRESS				Referring MDs		
CITY	STATE	ZIP				
Billing Information				CC report to: <u>First and Last Names</u>		
INSURANCE COMPANY NAME AND ADDRESS						
CITY	STATE	ZIP				
INSURANCE/SUBSCRIBER ID#	SUBSCRIBER NAME/RESPONSIBLE PARTY					
INSURANCE/GROUP#	MEDICARE#	<input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY				
SECONDARY	MEDICAID (coupon attached)					
<input type="checkbox"/> NO INSURANCE	WORKER'S COMP	<input type="checkbox"/> YES <input type="checkbox"/> NO				
INTERNAL USE ONLY						

DERMATOPATHOLOGY		
<input type="checkbox"/> Consult Request <input type="checkbox"/> Technical Only <input type="checkbox"/> Global - Technical & Professional		
Specimen A: <input type="checkbox"/> Shave Bx <input type="checkbox"/> Ellipse <input type="checkbox"/> Punch Bx <input type="checkbox"/> Check Margins <input type="checkbox"/> Excision <input type="checkbox"/> DIF <input type="checkbox"/> Shave Removal	Site: _____ Number of Pieces: _____	Clinical Findings & Diagnosis: _____ <input type="checkbox"/> Special Stains: _____
Specimen B: <input type="checkbox"/> Shave Bx <input type="checkbox"/> Ellipse <input type="checkbox"/> Punch Bx <input type="checkbox"/> Check Margins <input type="checkbox"/> Excision <input type="checkbox"/> DIF <input type="checkbox"/> Shave Removal	Site: _____ Number of Pieces: _____	Clinical Findings & Diagnosis: _____ <input type="checkbox"/> Special Stains: _____
Specimen C: <input type="checkbox"/> Shave Bx <input type="checkbox"/> Ellipse <input type="checkbox"/> Punch Bx <input type="checkbox"/> Check Margins <input type="checkbox"/> Excision <input type="checkbox"/> DIF <input type="checkbox"/> Shave Removal	Site: _____ Number of Pieces: _____	Clinical Findings & Diagnosis: _____ <input type="checkbox"/> Special Stains: _____
Specimen D: <input type="checkbox"/> Shave Bx <input type="checkbox"/> Ellipse <input type="checkbox"/> Punch Bx <input type="checkbox"/> Check Margins <input type="checkbox"/> Excision <input type="checkbox"/> DIF <input type="checkbox"/> Shave Removal	Site: _____ Number of Pieces: _____	Clinical Findings & Diagnosis: _____ <input type="checkbox"/> Special Stains: _____

01-13-2022