PATHOLOGY OUTPATIENT REQUEST FORM

DID YOU INCLUDE...
- DIAGNOSIS CODE(S)?
- TEST(S) TO BE PERFORMED?
- PROVIDER FIRST/LAST NAME?
- WHO TO BILL?

P.O. Box 196604 Anchorage, AK 99519-6604

PATHOLOGY (907) 212-3098 • FAX (907) 212-4873

ORDERING PROVIDER SIGNATURE:

RESEARCH STUDY NAME (IF APPLICABLE):

SEX (REQUIRED): ☐ MALE ☐ FEMALE ☐ OTHER

☐ **STAT**
Phone:_______________
Fax #:_______________
☐ Fax Results Immediately

PLEASE PRINT CLEARLY ALL INFORMATION MUST BE PROVIDED. USE BLACK OR BLUE INK ONLY.

PATIENT'S FULL LEGAL NAME (REQUIRED)

LAST:	FIRST:	MI:

DATE OF BIRTH (REQUIRED):

DIAGNOSIS ICD CODE(S) (REQUIRED):

ADDITIONAL COPIES TO:

BILL: ☐ **CLIENT/PHYSICIAN ACCOUNT #:______________________ COMPLETE REQUIRED AREAS** ☐ **PATIENT BILL COMPLETE REQUIRED AREAS BELOW** ☐ **INSURANCE COMPLETE ALL AREAS**

SUBSCRIBER (LAST, FIRST, MIDDLE)	DATE OF BIRTH

GUARANTOR (LAST, FIRST, MIDDLE) (REQUIRED EXCEPT FOR MEDICARE)	DATE OF BIRTH
ADDRESS	
CITY/STATE/ZIP CODE:	
PT. RELATIONSHIP:	
HOME PHONE NO.:	WORK PHONE NO.:

ADDRESS (CITY, STATE, ZIP)

PHONE #	PATIENT RELATIONSHIP

INSURANCE CO.

CLAIMS ADDRESS (CITY, STATE, ZIP)

INSURANCE PHONE	INSURANCE/MEMBER POLICY #	GROUP #

TODAY'S DATE (REQUIRED):	**COLLECTION DATE** (REQUIRED):	**COLLECTION TIME** (REQUIRED):

SURGEON____

☐ FROZEN SECTION PHONE #______________________________

SPECIMEN(S):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13.

CLINICAL HISTORY/PRE-OP, POST-OP DIAGNOSIS

____

LAB USE ONLY:

ACCESSION NUMBER: ______________________________

MEDICAL RECORD NUMBER: ______________________________

ACCOUNT NUMBER: ______________________________