REQUISITION FORM

Anatomic Pathology

EastPath Diagnostics, LLC
45-34 Bell Blvd, Bayside, NY 11361
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www.eastpathdx.com

PART A: Patient Information - *Required*

Patient Name:_____

Date of Birth_____ Gender M____F____

Address:_____

Social Security:_____ EMR#_____

Specimen collection date:_____

PART B: Provider Information - *Required*

Physician:_____

Address: _____

_____

Phone:_____ Fax:_____

NPI#_____ Signature_____

Send Duplicate Report to: Name_____ Address/Fax_____

PART C: Indications/Clinical History: _____

Required ICD-9 Code: 1)_____ 2)_____ 3)_____ 4)_____

PART D: Insurance Billing Information: *Send Bill to:* Patient:____ Insurance:____

Medicare:_____ Medicaid:_____ Self Pay:_____ Relation to Insured:_____

Insured Name:_____ Insured I.D._____ Group #:_____

Insurance Company Address:_____

Please Attach: 1) A copy of the front/back of patient's insurance card(s) or 2) Printout patient demographics and insurance information from your EHR

PART E: Specimen Information: # of Container:_____

A:_____ **G:**_____

B:_____ **H:**_____

C:_____ **I:**_____

D:_____ **J:**_____

E:_____ **K:**_____

F:_____ **L:**_____

FOR LAB USE ONLY:

Receiving Date:_____ Time:_____ Accession#_____ Note:_____