Cleveland Clinic
Laboratories

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

☐ STAT

DERMATOPATHOLOGY REQUISITION

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name	First MI
Address	Birth Date Sex ☐ M ☐ F
City	SS #
State Zip	Home Phone
Hospital/Physician Office Patient ID #	Accession #

INSURANCE BILLING INFORMATION (PLEASE PRINT IN BLACK INK)

BILL TO: ☐ Client ☐ Patient ☐ Insurance **(Complete insurance information below)**

ABN ☐ Yes ☐ No **WORKERS COMP:** ☐ Yes ☐ No DOI: _____

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name	First MI
Beneficiary / Member #	Group #
Claims Address	City State Zip

SECONDARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name	First MI
Beneficiary / Member #	Group #
Claims Address	City State Zip

DIAGNOSIS CODE (REQUIRED)

1. _____ 2. _____
3. _____ 4. _____

☐ Call results to phone number: (_____) _____

☐ Fax report to: (_____) _____

CLIENT INFORMATION

PHYSICIAN SIGNATURE REQUIRED

Physician Signature Date / Time

Physician Print Name NPI#

Date collected: ___/___/___ Time: _____

Collected by: _____

☐ Send additional report

Physician: _____

Address: _____

City, State, Zip: _____

MEDICAL NECESSITY NOTICE

When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

☐ Consultation on Prepared Slides/Blocks

SPECIMEN A	SPECIMEN B	SPECIMEN C
Check off Appropriate Type of Biopsy:	**Check off Appropriate Type of Biopsy:**	**Check off Appropriate Type of Biopsy:**
☐ PUNCH	☐ PUNCH	☐ PUNCH
☐ PUNCH EXCISION	☐ PUNCH EXCISION	☐ PUNCH EXCISION
☐ SHAVE	☐ SHAVE	☐ SHAVE
☐ SHAVE EXCISION	☐ SHAVE EXCISION	☐ SHAVE EXCISION
☐ CURETTINGS	☐ CURETTINGS	☐ CURETTINGS
☐ EXCISION	☐ EXCISION	☐ EXCISION
☐ WIDE EXCISION	☐ WIDE EXCISION	☐ WIDE EXCISION
MARGINS: ☐ Yes ☐ No	MARGINS: ☐ Yes ☐ No	MARGINS: ☐ Yes ☐ No
Biopsy Site : _____	Biopsy Site : _____	Biopsy Site : _____
Clinical History : _____	Clinical History : _____	Clinical History : _____
Additional Tests:	Additional Tests:	Additional Tests:
☐ DIRECT IMMUNOFLUORESCENSE	☐ DIRECT IMMUNOFLUORESCENSE	☐ DIRECT IMMUNOFLUORESCENSE
☐ ELECTRON MICROSCOPY	☐ ELECTRON MICROSCOPY	☐ ELECTRON MICROSCOPY
☐ IMMUNOHISTOCHEMISTRY	☐ IMMUNOHISTOCHEMISTRY	☐ IMMUNOHISTOCHEMISTRY
☐ MOLECULAR STUDIES	☐ MOLECULAR STUDIES	☐ MOLECULAR STUDIES

WHITE: Laboratory Copy YELLOW: Billing Copy PINK: Client Copy