Cabell Huntington Hospital

Lab Use Only

Dermatopathology Requisition Form

Wet/Fresh Tissue Specimens

1340 Hal Greer Boulevard Huntington, WV 25701

Phone: 304-526-2155 Fax: 304-399-4696

Specimen Collection/Procedure Date:_____

(**Required) Submitting/Requesting Physician's Signature:**

_____Date & Time:_____

Patient Information (or place patient demographic label)
SSN/CHH MRN:
Last Name/First/MI:
DOB:
__ Male __ Female
Address:
Phone:

Please complete the section below in its entirety

Submitting /Requesting Physician	**Other Physician to Receive Report**
Name: Last/First/Title NPI	Name:
Practice Name/Location:	Location/Address:
City/State/Zip	
Phone: Fax:	Phone: Fax:

Specimen Site (must match specimen container label)	**Procedure**	**Clinical Diagnosis/History/ICD10 Code**
A.		
B.		
C.		
D.		
E.		

Special Stains/Tests Requested	**Biopsy for alopecia?**	**Is one biopsy for IMMUNOFLOURESCENCE (DIF)? Which specimen?**
	___ Yes ___ No	___ Yes ___ No ___A ___B ___C

Insurance/Billing Information __ Bill Patient __ Bill Account		**Patient/ Guarantor Authorization**
Policy Holder's Name (Last/First/MI):	Relationship to patient:	I acknowledge my responsibility for all charges for these laboratory services requested on my behalf by my physician and authorize the release of information, including medical information, for this and any related claim to the named insurance company. I also agree to pay for all charges for any of these laboratory services that are not covered or are only partially covered/authorized by my insurance or Health Maintenance Organization.
___ Medicare # ___ Blue Cross/Anthem # ___ Other Ins. Name: __ Is Secondary Policy #: Group #: Auth. #:		Subscriber/Beneficiary Signature: _____ Date: _____

Please attach copy of insurance card(s)