To: FLINT MEDICAL LABORATORY INC.
3490 CALKINS ROAD
FLINT, MI 48532
PHONE: 810-733-8885 FAX: 810-733-8898

From:

REFERRING PHYSICIAN:

NAME _____ UPIN _____

ICD-9 DIAGNOSIS CODE(S) FOR TESTS ORDERED

PATIENT INFORMATION....PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (M.I.)

PATIENT S.S. # | SEX | BIRTHDATE

ADDRESS APT. #

CITY STATE ZIP

(AREA CODE) PHONE | PATIENT I.D. #

DATE COLLECTED

Send Duplicate Report To:

Name _____

Fax # _____ Phone # _____

BILL TO: PRIMARY ☐ Patient ☐ Medicare # ☐ Medicaid # ☐ HMO ☐ PPO ☐ Other

INSURANCE COMPANY NAME (attach card) EMPLOYER NAME

NAME OF INSURED INSURANCE / MEMBER ID # INSURED'S POLICY / GROUP #

RELATIONSHIP TO THE INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

MAIL CLAIM TO ADDRESS

CITY/STATE/ZIP

BILL TO: SECONDARY ☐ Patient ☐ Medicare # ☐ Medicaid # ☐ HMO ☐ PPO ☐ Other

INSURANCE COMPANY NAME (attach card) EMPLOYER NAME

NAME OF INSURED INSURANCE / MEMBER ID # INSURED'S POLICY / GROUP #

RELATIONSHIP TO THE INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

MAIL CLAIM TO ADDRESS

CITY/STATE/ZIP

PATHOLOGY REQUISITION

SPECIMEN NUMBER	SPECIMEN SOURCE / SITE	PRE / POST-OP DIAGNOSIS	MARGINS REQUESTED	COMMENTS	TYPE SPECIMEN
A (1)			☐		☐ Bx ☐ Ex ☐ P. Bx. ☐ Sh. Ex.
B (2)			☐		☐ Bx ☐ Ex ☐ P. Bx. ☐ Sh. Ex.
C (3)			☐		☐ Bx ☐ Ex ☐ P. Bx. ☐ Sh. Ex.
D (4)			☐		☐ Bx ☐ Ex ☐ P. Bx. ☐ Sh. Ex.
E (5)			☐		☐ Bx ☐ Ex ☐ P. Bx. ☐ Sh. Ex.

CLINICAL DATA / ANATOMIC SITE / DIAGNOSIS

BIOPSY REQUEST

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it will otherwise be covered, is not reasonable and necessary under the Medicare Program standards, Medicare will deny payment for that service. Medicare may deny payment if the diagnosis is not acceptable to them.
If Medicare denies payment, I agree to be personally and fully responsible for payment. I also give permission for Flint Medical Laboratory Inc. to send to my primary care/internist a copy of my final pathology reports determined from todays biopsies.

Patient Signature: _____ *Date:* _____