

To: **FLINT MEDICAL LABORATORY INC.**
3240 CALKINS ROAD
FLINT, MI 48532
PHONE 810-733-8885 FAX 810-733-8898

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			Name					
Fax #			Phone #					

From:

REFERRING PHYSICIAN:

NAME _____ UPIN _____

ICD-9 DIAGNOSIS CODE(S) FOR TESTS ORDERED

BILL TO: Patient Medicare # Medicaid #
 PRIMARY 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: Patient Medicare # Medicaid #
 SECONDARY 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)			<input type="checkbox"/>		<input type="checkbox"/> Bx <input type="checkbox"/> Ex <input type="checkbox"/> P. Bx. <input type="checkbox"/> Sh. Ex.
B (2)			<input type="checkbox"/>		<input type="checkbox"/> Bx <input type="checkbox"/> Ex <input type="checkbox"/> P. Bx. <input type="checkbox"/> Sh. Ex.
C (3)			<input type="checkbox"/>		<input type="checkbox"/> Bx <input type="checkbox"/> Ex <input type="checkbox"/> P. Bx. <input type="checkbox"/> Sh. Ex.
D (4)			<input type="checkbox"/>		<input type="checkbox"/> Bx <input type="checkbox"/> Ex <input type="checkbox"/> P. Bx. <input type="checkbox"/> Sh. Ex.
E (5)			<input type="checkbox"/>		<input type="checkbox"/> Bx <input type="checkbox"/> Ex <input type="checkbox"/> P. Bx. <input type="checkbox"/> 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 today's biopsies.

Patient Signature: _____ Date: _____