LMC PATHOLOGY SERVICES
An Aurora Diagnostics Partner

DERMATOPATHOLOGY REQUISITION

DERMDX Dermatopathology Services

LABEL HERE

CLIENT INFORMATION

Send duplicate report to	Name:	Fax:

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	PATIENT ID NUMBER

ADDRESS	☐ MALE ☐ FEMALE	DATE OF BIRTH / /
CITY / STATE / ZIP	PHONE ( )	

BILLING INFORMATION

PLEASE ATTACH A COPY OF THE PATIENT'S DRIVERS LICENSE - FRONT AND BACK - AND A COPY OF THE PATIENT'S INSURANCE CARD - FRONT AND BACK

Financial and release of information authorization: In consideration for services rendered, I/we hereby assign the benefits due me covering the services provided by Laboratory Medicine Consultants, including major medical benefits. I/we authorize the release of information necessary for insurance purposes. Furthermore, that in consideration of service rendered to the patient, I/we hereby obligate myself/ourselves to assume responsibility for full payment of account.

NAME OF INSURED (SUBSCRIBER)	LAST	FIRST	MI

PATIENT IS: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY INSURANCE ☐ PPO ☐ HMO	ID NUMBER	GROUP NAME/NUMBER

INSURANCE ADDRESS	CITY	STATE/ZIP

SECONDARY INSURANCE/ADDRESS ☐ PPO ☐ HMO	ID NUMBER	GROUP NAME/NUMBER

INSURED PATIENT SIGNATURE FOR FINANCIAL AND RELEASE OF INFORMATION ABN	DATE	PLEASE BILL (CHECK BOX) ☐ DOCTOR/CLIENT ☐ PATIENT ☐ INSURANCE

DIAGNOSIS (SPECIFY ICD 9)	1.	2.	3.	4.

IMPORTANT **MEDICARE PATIENTS: THE ADVANCE BENEFICIARY NOTICE, IF REQUIRED, MUST BE COMPLETED, SIGNED BY THE PATIENT, AND ATTACHED** IMPORTANT

SPECIMEN INFORMATION:	COLLECTION DATE ___/___/___	COLLECTION TIME ___:___ AM PM

CLINICAL HISTORY

SPECIMEN SITE	PROCEDURE	CLINICAL DIAGNOSIS	# PIECES SUBMITTED	OTHER INSTRUCTIONS
A				
B				
C				
D				

INTERPRETATION REQUESTED ☐ YES ☐ NO

☐ 2ND OPINION REQUESTED

☐ SKIN IMMUNOFLUORESCENCE

3059 S. MARYLAND PARKWAY, #100 • LAS VEGAS, NV 89109 • (TOLL FREE) 877-562-5227 • (P) (702) 732-3441 • (F) (702) 732-2310

WHITE - LAB USE 1 YELLOW - LAB USE 2 PINK - CLIENT COPY