Outpatient Cytopathology center

Histology/Cytology Requisition

Outpatient Cytopathology Center
2400 Susannah Street
Johnson City, TN 37601
Phone: 423-283-4734
Fax: 423-283-4736

LUAB E

Histo/Cyto #:
Date Received:
No. Containers:
Initials:

INSURANCE: Please furnish copy of insurance card WAIVER MUST BE SIGNED FOR ALL SPECIMENS

Date of Biopsy: _____

PATIENT

Name: _____
DOB: _____ SSN: _____
Physician Name: _____
Physician Address: _____
_____
Physician Phone: _____
Chart #: _____ Race: _____ Sex: M F

BILLING

☐ Insurance Bill ☐ Patient Bill

Billing Information for Insurance or Direct Bill:
Patient Address: _____
_____
Patient Telephone: _____

☐ See Attached Demographics and Copy of Insurance Card

HISTORY

Please check all that apply:
☐ Prior Malignancy
Type: _____
☐ Sun Exposure
☐ Other History: _____
_____
_____
_____

SPECIMEN

Breast Nipple Secretion:
☐ Left ☐ Right ☐ Bilateral Color _____
Urine Specimen: MUST BE REFRIGERATED
☐ Voided ☐ Instrumented Time Collected: _____
History: _____
_____
_____

	SPECIMEN LOCATION	METHOD OF BIOPSY FOR EACH SPECIMEN
1		___ Excisional ___ Punch ___ Shave ___ Fluid ___ FNA
2		___ Excisional ___ Punch ___ Shave ___ Fluid ___ FNA
3		___ Excisional ___ Punch ___ Shave ___ Fluid ___ FNA
4		___ Excisional ___ Punch ___ Shave ___ Fluid ___ FNA
5		___ Excisional ___ Punch ___ Shave ___ Fluid ___ FNA

Waiver of Liability for Medicare or Commercial Insurance Coverage

Provider Notice

Medicare will only pay for services that are determined to be "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare is likely to deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for pathology services.

Beneficiary Agreement

"I have been notified by my physician that (s)he believes that, in my case, Medicare and/or my commercial insurance is likely to deny payment for the services identified on the reverse side, for the reasons stated. If my insurance company denies payment, I agree to be personally and fully responsible for payment."

Signed _____ Date _____

Witnessed _____