

Last Name		First Name		MI	Sex	Date of Birth	Social Security Number	
Address			City		State		Zip Code	
Home Telephone		Guarantor Name			Guarantor Address			
Employer		Employer Address				Employer Phone Number		
Primary Insurance					ID#			
Insurance Address					Group #			
Policy Holder			Relation to Patient		Authorization HMO Ref. #			
Secondary Insurance					ID#			
Insurance Address					Group #			
Policy Holder			Relation to Patient		Authorization HMO Ref. #			
Medicare Qualification		Public Health Service			Admitted Last 60 Days			
<input type="checkbox"/> age > 65 <input type="checkbox"/> age < 65 with disability <input type="checkbox"/> on dialysis <input type="checkbox"/> N/A		<input type="checkbox"/> Black Lung benefits <input type="checkbox"/> special govt. program <input type="checkbox"/> not applicable			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date Collected	Time Collected	<input type="checkbox"/> ROUTINE		<input type="checkbox"/> CALL RESULTS		LAB ACC. #		
/ /		<input type="checkbox"/> AM <input type="checkbox"/> PM						
Ordering Physician			Location					
Additional copies to:								

ALLIED DIAGNOSTIC
PATHOLOGY CONSULTANTS, P.A.
 Medical Services Building
 7th & Clayton Sts.
 Wilmington, DE 19805
 Tel. 302-575-8103 or 8104
 Fax 302-575-8139

INSURANCE/PAYMENT AUTHORIZATION

I hereby authorize payment to Allied Diagnostic Pathology Consultants, PA for insurance benefits otherwise payable to me for the itemized medical services they provided. I understand I am financially responsible for the charges not covered by this authorization. I also hereby authorize release of all necessary information regarding these services as may be required in order to achieve resolution of these claims.

 Patient/Responsible Person (relationship) Signature Date

MEDICARE PATIENTS ONLY

1. I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that the payment of authorized benefits be made in my behalf. I assign payment of the unpaid charges of the physician(s) in connection with the service. I understand I am responsible for any health insurance deductibles and co-pays as determined by the insurance carrier.

2. 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 would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. If Medicare does deny my claim I understand I will receive a bill for the test(s) and I agree to be responsible for the payment of that bill.

 Patient/Responsible Person (relationship) Signature Date

INFORMATION BELOW IS IMPORTANT FOR PROPER INTERPRETATION

Pertinent Clinical History/Operative Findings

Clinical Diagnosis/ICD9 Code

SURGICAL PATHOLOGY SPECIMEN

- Breast Incisional Biopsy w/o margins
- Cervix Excisional Biopsy Reduction
- Endometrium Biopsy Cone LEEP
- Endocervix Curettage
- Prostate Needle Biopsy TUR
- Vas Deferens
- Bladder Biopsy TUR
- Esophagus Biopsy
- Stomach Biopsy Polyp
- Colon Biopsy Polyp
- Lymph Node Biopsy
- Skin Punch Shave Excision
- Other _____

NON-GYNECOLOGIC CYTOLOGY

- Breast Right Left
- Bronchial Brushing Right Left
- Bronchial Washing Right Left
- CSF
- Fine Needle Aspiration
- Site: _____
- Pleural Fluid Right Left
- Peritoneal Fluid
- Sputum
- Urine Voided Catheterized Washing
- Other _____

GYNECOLOGIC CYTOLOGY (Pap Smear)

- LMP _____
- Previous Pap smear Date _____
- Pap smear is submitted simultaneously with biopsy
- Pregnant Abnormal Bleeding
 - Post partum Oral Contraceptives
 - Post Abortion IUD
 - Post Menopausal DES Exposure
 - Hormonal Therapy (Please specify)
 - Other _____