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. #**

Date Collected / /	Time Collected ☐ AM ☐ PM	☐ ROUTINE	☐ CALL RESULTS	LAB ACCT. #

Collected by:	Location

Ordering Physician

Additional copies to:

ALLIED PATHOLOGY

Let us make it easy for you

701 N. Clayton Street, MSB 301
Wilmington, DE 19805

Tel. 302-575-8103 or 8104 • Fax 302-575-8139

WWW.ALLIEDDIAGNOSTIC.COM

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/ICD10 Code

SURGICAL PATHOLOGY SPECIMEN

☐ Breast ☐ Incisional Biopsy w/o margins ☐ Excisional Biopsy ☐ Reduction
☐ Cervix ☐ Biopsy ☐ Cone ☐ LEEP
☐ Endometrium ☐ Biopsy ☐ Curettage
☐ 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_____

MICROBIOLOGY SPECIMEN

Aerobic = 2 swabs

☐ Aerobic culture and gram stain (aerobic transport swab)
☐ Fungus culture (aerobic or specimen in sterile container)
☐ Anaerobic culture and gram stain (anaerobic transfer swab)
☐ Acid fast bacilli culture and smear (aerobic or specimen in sterile container)
☐ Other (use if not listed above)
_____