

PHYSICIAN INFORMATION	PATIENT INFORMATION
Requesting Physician Signature _____ Copy to _____	Last Name _____ First Name _____ MI _____ Date of Birth _____ Street Address _____ City _____ State _____ Zip _____ Gender <input type="checkbox"/> F <input type="checkbox"/> M _____ ( ) - _____ Chart Number _____ Patient Telephone No. _____

BILLING INFORMATION REQUIRED (Attach copies of Insurance card: Primary and Secondary)	
If minor, Guardian Name _____ Insurance Co. _____	
Subscriber # _____ Group # _____ Relation to Patient: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> guardian	
Insured's Name _____ Insured Employer _____	
<input type="checkbox"/> Bill Insurance <input type="checkbox"/> Uninsured <input type="checkbox"/> Indigent Patient <input type="checkbox"/> Bill Doctor <input type="checkbox"/> Medicare Waiver (ABN instructions on back)	

TISSUE SPECIMEN	
Collection Date: _____ Time: _____ Specimen ID #(s): _____ ICD-9 Code REQUIRED: _____	
<small>ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.</small>	
<b>Biopsy Data</b> (Please identify anatomic site and impression site below and apply appropriate specimen to label)	









Specimen	Specimen Type: <input type="checkbox"/> STAT <input type="checkbox"/> Routine	Anatomic Site	Impression
A	<input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Other: _____		
B	<input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Other: _____		
C	<input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Other: _____		
D	<input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Other: _____		
E	<input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Other: _____		
F	<input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Other: _____		

CLINICAL HISTORY	
Previous Biopsy: _____	
Additional Patient History: _____	
<b>Additional Requests:</b> <input type="checkbox"/> Special Stains <input type="checkbox"/> Immunopathology <input type="checkbox"/> Other Instructions: _____ <b>Consultation:</b> <input type="checkbox"/> Consult Slide: Slide Number: _____ <input type="checkbox"/> Keep Slide <input type="checkbox"/> Return Slide <b>Additional Consultation Questions, Requests, or Notes:</b> _____	<b>For LAB USE ONLY</b> CYTO Accession # _____ TISSUE Accession # _____ DATE/TIME Rec'd _____

**Positive Patient Identification: No.**

**Specimen Label Instructions:**

1. Remove the necessary labels and place one (1) label on each specimen container (not on the lid).
2. Please be sure to write in any required information on the labels.

			
Last: _____	Last: _____	Last: _____	Last: _____
First: _____	First: _____	First: _____	First: _____
Site: _____	Site: _____	Site: _____	Site: _____
			
Last: _____	Last: _____	Last: _____	Last: _____
First: _____	First: _____	First: _____	First: _____
Site: _____	Site: _____	Site: _____	Site: _____



**A. Notifier:**

6116 E Warren Ave ● Denver, CO 80222 ● Phone: (303) 512-0888 ● Fax: (303) 512-2246

**B. Patient Name:**

**C. Identification Number:**

**Advance Beneficiary Notice of Noncoverage (ABN)**

**NOTE:** If Medicare doesn't pay for the **D. laboratory test(s)** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. laboratory test(s)** below.

D. Laboratory Test(s)	E. Reason Medicare May Not Pay:	F. Estimated Cost

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. laboratory test(s)** listed above.  
**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

<p><b>G. OPTIONS: Check only one box. We cannot choose a box for you.</b></p> <p><input type="checkbox"/> <b>OPTION 1.</b> I want the <b>D. laboratory test(s)</b> listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but <b>I can appeal to Medicare</b> by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.</p> <p><input type="checkbox"/> <b>OPTION 2.</b> I want the <b>D. laboratory test(s)</b> listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. <b>I cannot appeal if Medicare is not billed.</b></p> <p><input type="checkbox"/> <b>OPTION 3.</b> I don't want the <b>D. laboratory test(s)</b> listed above. I understand with this choice I am <b>not</b> responsible for payment, and <b>I cannot appeal to see if Medicare would pay.</b></p>
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**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

<p><b>I. Signature:</b></p>	<p><b>J. Date:</b></p>
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.