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Dermatopathology Test Requisition

PATIENT INFORMATION

Last Name:	First Name:	MI:	Bill To: ☐ Insurance ☐ Patient
Date of Birth:	Gender: ☐ M ☐ F ☐ Other	MRN:	Please attach copy of insurance documents

ORDERING PHYSICIAN

Name:
Address

Phone:
Fax:

COPY TO PHYSICIAN

Name:
Address:

Phone:
Fax:

SPECIMEN INFORMATION

Date of Service: Time:

A) Specimen: ☐ Punch ☐ Shave ☐ Excision ☐ Other:	Specimen Site: Description: Clinical Note:
B) Specimen: ☐ Punch ☐ Shave ☐ Excision ☐ Other:	Specimen Site: Description: Clinical Note:
C) Specimen: ☐ Punch ☐ Shave ☐ Excision ☐ Other:	Specimen Site: Description: Clinical Note:

CHECKLIST FOR SUBMITTING SPECIMENS:

□ Be sure specimen containers are properly labeled with (patient name, DOB, date/time collected, specimen source)
□ Include completed Lucent Pathology Specimen requisition
□ Please provide all relevant documents: Insurance, demographics, and clinical history

For further assistance please contact Customer Service at cs@lucentpathology.com or (916) 778-8999

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ 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.**_____ below.

D.	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.**_____ 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.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ 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 I can appeal to Medicare 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.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

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.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.