

SUBMITTING PHYSICIAN INFORMATION



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PATIENT INFORMATION

BILLING INFORMATION

Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Insurance	Secondary Insurance
Patient Name (Last, First, Middle Initial)		Insurance Company	Insurance Company
Address		Member ID	Member ID
City	State	ZIP Code	Group Number
Phone Number		Name of Insured	Name of Insured
Medical Record Number (Optional)		Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent

SPECIMEN INFORMATION

DATE OF PROCEDURE: _____ PHYSICIAN SIGNATURE: _____
 Physician authorizes Imgen Diagnostics, Inc. to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient accordingly.

Please write patient name and DOB on all specimen bottles

URINE	<input type="checkbox"/> Urine for Cytology*	<input type="checkbox"/> Voided Urine ICD-10: _____
	<input type="checkbox"/> *If Urine Abnormal Reflex to FISH	<input type="checkbox"/> Washing ICD-10: _____
BIOPSY	<input type="checkbox"/> Urine for FISH analysis**	<input type="checkbox"/> Catheterized Urine ICD-10: _____
	<input type="checkbox"/> **If FISH Abnormal Reflex to Cytology	
	<input type="checkbox"/> Bladder Biopsy ICD-10: _____	<input type="checkbox"/> Other Biopsy ICD-10: _____
	<input type="checkbox"/> Vas Deferens (Left) ICD-10: _____	
	<input type="checkbox"/> Vas Deferens (Right) ICD-10: _____	

Prostate Biopsy (For all 12 biopsies, check standard. For additional biopsies, complete additional labels.)

<input type="checkbox"/> Standard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Left Apex	Left Lateral Apex	Right Apex	Right Lateral Apex	Left Mid	Left Lateral Mid	Right Mid	Right Lateral Mid	Left Base	Left Lateral Base	Right Base	Right Lateral Base					
	LA	LLA	RA	RLA	LM	LLM	RM	RLM	LB	LLB	RB	RLB					

SPECIMEN INFORMATION

DATE OF PROCEDURE: _____	PSA RESULT: _____	ICD-10: _____
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