DERMPATH DIAGNOSTICS®
AMERIPATH CLEVELAND

DERMATOPATHOLOGY REQUISITION

☐ IMMUNOFLUORESCENCE ☐ RUSH

PATIENT INFORMATION

Last Name	First Name	M.I.
Street Address		Apt. #
City	State	Zip
Patient Phone Number	Patient Social Security Number	
Date of Birth / /	Age	Sex	Patient ID

BILLING/INSURANCE (Attach copy of insurance card - both sides)

Bill:
☐ Insurance
☐ Medicare
☐ Medicaid
☐ Worker's Comp
☐ Patient
☐ Physician
☐ Hospital
☐ Other

☐ Outpatient/ Non-hospital
☐ Hospital (IP/OP/ER)

Subscriber Insurance ☐ Secondary Insurance Information Attached

Subscriber Name / Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

Company Name

Address

City	State	Zip

Employer Name

Subscriber DOB: / /	Group/Contract #	Member ID#
Subscriber Sex: ☐ Male ☐ Female	Medicare#	Medicaid ID#

CLIENT INFORMATION

Treating Physician	**NPI # (required)**	UPIN #

Physician's Signature X _____ Required for NY, NJ, MA and WV

Send duplicate of report to:

Name _____

Address/Fax _____

CLINICAL INFORMATION

SITE	CHECK:	MARGINS?	CLINICAL DIAGNOSIS AND HISTORY
A	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
B	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
C	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
D	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
E	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
F	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	

Date Collected: ___/___/___ Time: _____ By: _____

FOR LAB USE ONLY

ICD Codes:

These offerings may require special studies, markers or stains as deemed appropriate for proper evaluation by AmeriPath pathologist. These additional tests may result in additional charges.

AmeriPath Cleveland ● 7730 First Place, Suite A, Building F ● Oakwood Village, OH 44146 ● (440) 703-2100 ● Fax (440) 703-2155

AMERIPATH LAB USE 1

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Subscriber Name / Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

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Address

City	State	Zip

Employer Name

Subscriber DOB: / /	Group/Contract #	Member ID#
Subscriber Sex: ☐ Male ☐ Female	Medicare#	Medicaid ID#

CLIENT INFORMATION

Treating Physician	**NPI # (required)**	UPIN #

Physician's Signature X _____ Required for NY, NJ, MA and WV

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B	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
C	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
D	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
E	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
F	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	

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AMERIPATH LAB USE 2

DERMPATH DIAGNOSTICS®
AMERIPATH CLEVELAND

DERMATOPATHOLOGY REQUISITION

☐ IMMUNOFLUORESCENCE ☐ RUSH

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City	State	Zip
Patient Phone Number	Patient Social Security Number	
Date of Birth / /	Age	Sex	Patient ID

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☐ Medicaid
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☐ Patient
☐ Physician
☐ Hospital
☐ Other

☐ Outpatient/ Non-hospital
☐ Hospital (IP/OP/ER)

Subscriber Insurance ☐ Secondary Insurance Information Attached

Subscriber Name / Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

Company Name

Address

City | State | Zip

Employer Name

Subscriber DOB: / / | Group/Contract # | Member ID#

Subscriber Sex: ☐ Male ☐ Female | Medicare# | Medicaid ID#

CLIENT INFORMATION

Treating Physician | **NPI # (required)** | UPIN #

Required for NY, NJ, MA and WV

Physician's Signature X _____

Send duplicate of report to:

Name _____

Address/Fax _____

CLINICAL INFORMATION

SITE	CHECK:	MARGINS?	CLINICAL DIAGNOSIS AND HISTORY
A	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
B	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
C	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
D	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
E	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
F	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	

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