StrataDx
ONE CRANBERRY HILL
SUITE 303
LEXINGTON, MA 02421
Phone: 800-325-7284 Fax: 617-401-4032

Req. 100000

DATE OF PROCEDURE: _____

PATIENT INFORMATION

_____
Date of Birth
Sex: ☐ Female ☐ Male

_____
Name (Last, First, Middle Initial)

_____
Address

_____
City State ZIP Code

_____ _____
Telephone Number Medical Record Number (Optional)

BILLING INFORMATION

Please attach copy of patient's insurance card

☐ Insurance Information Attached	☐ Insurance not on file, Contact Patient directly to obtain
☐ Client Bill	☐ Please Bill the Patient Directly

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insurance Company	Insurance Company
Member ID	Member ID
Group Number	Group Number
Insured Name	Insured Name
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent	Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

SPECIMEN INFORMATION

	PROCEDURE TYPE		BIOPSY SITE	CLINICAL IMPRESSION
A	☐ Biopsy ☐ Excision ☐ Re-Excision ☐ Shave ☐ Punch	☐ Curette ☐ Nail ☐ Direct Immuno ☐ Indirect Immuno		
B	☐ Biopsy ☐ Excision ☐ Re-Excision ☐ Shave ☐ Punch	☐ Curette ☐ Nail ☐ Direct Immuno ☐ Indirect Immuno		
C	☐ Biopsy ☐ Excision ☐ Re-Excision ☐ Shave ☐ Punch	☐ Curette ☐ Nail ☐ Direct Immuno ☐ Indirect Immuno		
D	☐ Biopsy ☐ Excision ☐ Re-Excision ☐ Shave ☐ Punch	☐ Curette ☐ Nail ☐ Direct Immuno ☐ Indirect Immuno		

Physician Signature:

_____

I certify that I have obtained the required authorization and assignment of benefits for the laboratory to bill when insurance billing has been requested above. Physician authorizes Strata Pathology Services to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient accordingly.

FORWARD ADDITIONAL COPY OF REPORT TO

*Dr. Name (first, last):

_____

*Fax:

_____

Required information to forward reports

100000 A
Patient Name/Initials:
_____
DOB:
_____
Site:
_____
To ensure processing, affix completed label to specimen container.

100000 B
Patient Name/Initials:
_____
DOB:
_____
Site:
_____
To ensure processing, affix completed label to specimen container.

100000 C
Patient Name/Initials:
_____
DOB:
_____
Site:
_____
To ensure processing, affix completed label to specimen container.

100000 D
Patient Name/Initials:
_____
DOB:
_____
Site:
_____
To ensure processing, affix completed label to specimen container.