

Dermatopathology Requisition

We file all primary and secondary insurance plans if information is provided. Secondary insurance information on back.



All cases are assumed Global (process and interpret). If **NOT** Global, please indicate: Slide Process Only (TC) Interpretation Only (PC)

| PATIENT INFORMATION (Items in tinted boxes are required) | | | |
|--|----------------------|---------------------------|-----|
| Date of Collection / / | Date of Birth / / | Age | Sex |
| Last Name | | | |
| First Name | | | MI |
| Street Address | | Apt# | |
| City | | State | Zip |
| Patient Phone # | | Patient Alternate Phone # | |
| Patient Social Security # | | Patient Medical Record # | |

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| BILLING INFORMATION – PRIMARY INSURED (Secondary information on back) | | | |
|--|-----------------------------------|---|--|
| Insurance Carrier | Policy Number / Insured ID Number | Group Number | |
| Claims Address | | Policy Holder's Name | |
| City | | State | Zip |
| Insured's Relationship To Patient <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent | | Policy Holder's DOB / / | Sex <input type="radio"/> M <input type="radio"/> F |
| Policy Holder's Address | | City | State |
| | | Zip | Claims Phone # |
| | | If Uninsured Patient <input type="radio"/> Self Pay <input type="radio"/> Indigent | |

| DERMATOPATHOLOGY TEST REQUEST (Check all that apply) | | | | | | | | | Clinical Impression / History / Prior Pathology | Specimen Labels |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|---|---|
| | Shave | Punch | Curette | Biopsy | Excision | Re-Excision | Left | Right | | |
| A | <input type="radio"/> | Site A | Patient: _____ Site A: _____ Clinician: _____ |
| B | <input type="radio"/> | Site B | Patient: _____ Site B: _____ Clinician: _____ |
| C | <input type="radio"/> | Site C | Patient: _____ Site C: _____ Clinician: _____ |
| D | <input type="radio"/> | Site D | Patient: _____ Site D: _____ Clinician: _____ |

| SPECIAL TESTS / CONSULTATION / SECOND OPINION (Continued on reverse) | | |
|--|---|--|
| <input type="radio"/> Consultation / Second Opinion | Immunofluorescence: <input type="radio"/> Direct <input type="radio"/> Indirect | In situ hybridization for HPV <input type="radio"/> High Risk (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58 and 66) <input type="radio"/> Low Risk (6 and 11) |
| Gene rearrangement studies for cutaneous lymphoproliferative disorders <input type="radio"/> T-cell receptor <input type="radio"/> B-cell receptor | Melanoma Fluorescence in situ hybridization (FISH) assay <input type="radio"/> FISH test with consultation <input type="radio"/> FISH test only | See reverse for additional tests. |

In accordance with Medicaid and Medicare requirements, only medically necessary testing for the diagnosis and treatment of patients is performed.

Salari Skin Pathology LLC

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Billing/Lab (White) Client (Yellow)

Version 2026.2

FOR LAB USE ONLY

SPECIAL TESTS (Continued)

Malignant Melanoma mutational analysis:

- BRAF
- Kit
- NRAS
- PTEN expression by IHC

Other:

BILLING INFORMATION – SECONDARY INSURED

| | | | | | |
|--|--|-----------------------------------|-------|--|----------------|
| Insurance Carrier | | Policy Number / Insured ID Number | | Group Number | |
| Claims Address | | | | Policy Holder's Name | |
| City | | | State | Zip | Claims Phone # |
| Insured's Relationship To Patient <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent | | Policy Holder's DOB / / | | Sex <input type="radio"/> M <input type="radio"/> F | |
| If Uninsured Patient <input type="radio"/> Self Pay <input type="radio"/> Indigent | | | | | |
| Policy Holder's Address | | | City | State | Zip |

I authorize the release of medical information related to services provided herein to my health plan / insurance carrier and authorize payment directly to:

_____ and/or other lab service provider. I assume responsibility for payment of charges not covered by my healthcare insurer.

Patient's Signature _____ Date _____