

800-325-PATH (7284) 1 Cranberry Hill Suite 303 Lexington, MA 02421

PHYSICIAN/CLINIC INFORMATION

LAB USE ONLY

				SO12201901	
14192 Rev012920	PATIENT INFORMA	TION			
Date of Birth: / /	Phone #:	-	Sex: Fer	male Male	
Last Name:				e Initial:	
Address:					
state: Zip Code: Me					
	CLINICAL INFORMA				
Pate of Procedure:///			Type of Specimen:		
			☐ INC BX	Excision	
Biopsy Site:			CUR	APICO	
Physician Signature:				Direct Immunofluorescence ed in Michel's Media	
Physician authorizes Strata Pathology Services, Inc. to perfor	m all appropriate laboratory services	related to this specime	n(s) and to bill payor/patie	ent accordingly.	
Clinical & Radiographic Findings: Clinical Photos/Radiographs Included					
Clinical Impression:	<i>To ens</i> !	A	completed label to specific	ecimen container. B	
		/Initials:		nla.	
	DOB:	Site:	DOB:	Site:	
SENI	D ADDITIONAL COPY C			Oite.	
Physician's Name:					
	PATIENT BILLING INFO				
I have read the Billing Guidelines and I understa Patient/Responsible Party Name:	and my responsibilities as des	cribed within.			
Signature:					
By signing, I understand that the tests requested on this for and/or investigational by my insurance carrier and I authori. for copays/deductibles or for the amount described below for	ze the services to be performed rega	rdless. I have been info	ormed and agree that I wil	l be financially responsible	
Primary Medical Insurance	J Services deemed out-of-fretwork, I		ary Medical Insura	3 3	
nsurance Provider:	Insuran		-		
/lember ID:	Membe	er ID:			
Group #:	Group	#:			
nsured Name:	Insured	l Name:			
Patient's Relationship to Insured: Self Spou	se Dependent Patient				
oose one payment option (required):					
Self Pay (Provide payment information to the right) Non-immunofluorescence: 1st specimen - \$159; each additional information in the right) Direct Immunofluorescence: \$479	orial specimen - \$79,	with Credit Card:	estercard		
Bill Insurance / Medicare (Provide credit card payment information to the right) Your insurance provider will be billed for the full amount due highlighted area above, if your insurance provider determine due by you, your credit card will be charged a maximum of \$\frac{3}{2}\$ amount due beyond this will be billed to you separately. If the necessary to correctly bill your insurance provider is not proceedit card will be charged per the Self-Pay process.	Expiratio Per the yellow as any amount is 5179. Any the information vided, your Expiration Cardholo Cardholo	n Date: / ler Full Name:	CV		
Bill Medicaid We are a Medicaid provider for: CO, CT, IL, KY, ME, MD, M, NM, NC, PA, SC, and VT. Your Medicaid provider will be bills	Chec	ck Amount: \$	necks payable to: StrataD:	Staple check to this	



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17 102 1/GVU 1232U	PATIENT INFORMATIO	N			
Date of Birth: / /	Phone #:	Sex: Female	Male		
_ast Name:		_	al:		
Address:					
State: Zip Code: Me					
	CLINICAL INFORMATION				
Date of Procedure: / / /		Type of Specimen:			
Biopsy Site:			cision		
		CUR AP	PICO		
Physician Signature:		*Must be submitted in I	Michel's Media		
Physician authorizes Strata Pathology Services, Inc. to perfo	orm all appropriate laboratory services relate	I to this specimen(s) and to bill payor/patient acc	cordingly.		
Clinical & Radiographic Findings: Clinical Photos/Radiographs Included					
linical Impression:		To ensure processing, affix completed label to specimen container.			
	SO12201901	A			
		Patient Name/Initials:			
	DOB:	Site: DOB: Sit			
SEN	ID ADDITIONAL COPY OF R		ie.		
	ID ADDITIONAL COLLOCK				
Physician's Name:	PATIENT BILLING INFORM	Fax #:			
I have read the Billing Guidelines and I underst	tand my responsibilities as describe	d within.			
Patient/Responsible Party Name:					
By signing, I understand that the tests requested on this for	orm may be out-of-network for my insurance		ssary, experimental,		
and/or investigational by my insurance carrier and I author for copays/deductibles or for the amount described below					
Primary Medical Insurance		Secondary Medical Insurance			
nsurance Provider:		ovider:			
Member ID:					
Group #:					
nsured Name:		e: ationship to Insured: Self Spous			
Patient's Relationship to Insured: Seir Spo	Dependent Patient's Rel	ationship to insured: Seif Spous			
oose one payment option (required):					
Self Pay (Provide payment information to the right)	Day with (Credit Card: VISA AM			
Non-immunofluorescence: 1st specimen - \$159; each addit Direct Immunofluorescence: \$479	monar specimen - \$79,	Pay with Credit Card: VISA Credit Card #:			
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(Provide credit card payment information to the right) Your insurance provider will be billed for the full amount du highlighted area above, if your insurance provider determin	ie. Per the yellow	e: / CVV:			
due by you, your credit card will be charged a maximum of amount due beyond this will be billed to you separately. If i	f \$179. Any the information	Cardholder Full Name: Cardholder Signature:			
necessary to correctly bill your insurance provider is not proceedit card will be charged per the Self-Pay process.	rovided, your Cardnoider Signature				
Dill Madiacid		Check (Self Pay option only) ount: \$			
Bill Medicaid We are a Medicaid provider for: CO, CT, IL, KY, ME, MD, NM, NC, PA, SC, and VT. Your Medicaid provider will be bil	MA, NE, NH, NJ,	(Make checks payable to: StrataDx)	Staple check to this		