StrataDx
CENTER FOR ORAL PATHOLOGY

800-325-PATH (7284)

1 Cranberry Hill
Suite 303
Lexington, MA 02421

PHYSICIAN/CLINIC INFORMATION

LAB USE ONLY

SO12201901

14192 Rev012920

PATIENT INFORMATION

Date of Birth: __ __ / __ __ / __ __ __ __ Phone #: __ __ __ - __ __ __ - __ __ __ __ Sex: ☐ Female ☐ Male

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt/Suite: _____ City: _____

State: __ __ Zip Code: _____ Medical Record # (optional): _____

CLINICAL INFORMATION

Date of Procedure: __ __ / __ __ / __ __ __ __

Biopsy Site: _____

Physician Signature: _____

Type of Specimen:

☐ INC BX ☐ Excision
☐ CUR ☐ APICO
☐ Specimen for Direct Immunofluorescence*
*Must be submitted in Michel's Media

Physician authorizes Strata Pathology Services, Inc. to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient accordingly.

Clinical & Radiographic Findings:

☐ Clinical Photos/Radiographs Included

Clinical Impression:

To ensure processing, affix completed label to specimen container.

A	B
SO12201901	SO12201901
Patient Name/Initials: _____	Patient Name/Initials: _____
DOB: Site:	DOB: Site:

SEND ADDITIONAL COPY OF REPORT TO

Physician's Name: _____ Fax #: __ __ __ - __ __ __ - __ __ __ __

PATIENT BILLING INFORMATION

I have read the Billing Guidelines and I understand my responsibilities as described within.

Patient/Responsible Party Name: _____

Signature: _____ Today's Date: __ __ / __ __ / __ __ __ __

By signing, I understand that the tests requested on this form may be out-of-network for my insurance plan and/or may be deemed not medically necessary, experimental, and/or investigational by my insurance carrier and I authorize the services to be performed regardless. I have been informed and agree that I will be financially responsible for copays/deductibles or for the amount described below for services deemed out-of-network, not medically necessary, experimental, and/or investigational by my insurer.

Primary Medical Insurance

Insurance Provider: _____

Member ID: _____

Group #: _____

Insured Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

Secondary Medical Insurance

Insurance Provider: _____

Member ID: _____

Group #: _____

Insured Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

Choose one payment option (required):

☐ **Self Pay** (Provide payment information to the right)
Non-immunofluorescence: 1st specimen - $159; each additional specimen - $79; Direct Immunofluorescence: $479

☐ **Bill Insurance / Medicare**
(Provide credit card payment information to the right)
Your insurance provider will be billed for the full amount due. Per the yellow highlighted area above, if your insurance provider determines any amount is due by you, your credit card will be charged a maximum of $179. Any amount due beyond this will be billed to you separately. If the information necessary to correctly bill your insurance provider is not provided, your credit card will be charged per the Self-Pay process.

☐ **Bill Medicaid**
We are a Medicaid provider for: CO, CT, IL, KY, ME, MD, MA, NE, NH, NJ, NM, NC, PA, SC, and VT. Your Medicaid provider will be billed for services.

☐ Pay with Credit Card: mastercard VISA AMEX

Credit Card #: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: __ __ / __ __ __ __ CVV: _____

Cardholder Full Name: _____

Cardholder Signature: _____

☐ Pay with Check (Self Pay option only)

Check Amount: $_____

(Make checks payable to: StrataDx) *Staple check to this form*

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Primary Medical Insurance

Insurance Provider: _____

Member ID: _____

Group #: _____

Insured Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

Secondary Medical Insurance

Insurance Provider: _____

Member ID: _____

Group #: _____

Insured Name: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

Choose one payment option (required):

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We are a Medicaid provider for: CO, CT, IL, KY, ME, MD, MA, NE, NH, NJ, NM, NC, PA, SC, and VT. Your Medicaid provider will be billed for services.

☐ Pay with Credit Card: mastercard VISA AMEX

Credit Card #: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: __ __ / __ __ __ __ CVV: _____

Cardholder Full Name: _____

Cardholder Signature: _____

☐ Pay with Check (Self Pay option only)

Check Amount: $_____

(Make checks payable to: StrataDx) *Staple check to this form*