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

BILLING INFORMATION

Please attach copy of patient's insurance card

☐ Insurance Information Attached ☐ Client Bill

☐ Insurance not on file, Contact Pa ent directly to obtain

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

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)

SPECIMEN INFORMATION

	PROCEDURE TYPE		BIOPSY SITE	CLINICAL IMPRESSION
A	**NAIL UNIT DYSTROPHY** (Fungal, Inflammatory, Neoplasm) ☐ Nail High Sensitivity) (PAS/GMS ☐ Nail - Low Sensitivity (PAS) ☐ Reflex to PCR/DNA, only if positive (3-4 days) ☐ Always add PCR/DNA (2 days) ☐ Reflex to Culture, only if negative (2-4 weeks)	**Skin/Tissue** ☐ Excision ☐ Re-Excision ☐ Punch ☐ Shave ☐ Curette		
B	**NAIL UNIT DYSTROPHY** (Fungal, Inflammatory, Neoplasm) ☐ Nail - High Sensitivity (PAS/GMS) ☐ Nail - Low Sensitivity (PAS) ☐ Reflex to PCR/DNA, only if positive (3-4 days) ☐ Always add PCR/DNA (2 days) ☐ Reflex to Culture, only if negative (2-4 weeks)	**Skin/Tissue** ☐ Excision ☐ Re-Excision ☐ Punch ☐ Shave ☐ Curette		
C	**NAIL UNIT DYSTROPHY** (Fungal, Inflammatory, Neoplasm) ☐ Nail - High Sensitivity (PAS/GMS) ☐ Nail - Low Sensitivity (PAS) ☐ Reflex to PCR/DNA, only if positive (3-4 days) ☐ Always add PCR/DNA (2 days) ☐ Reflex to Culture, only if negative (2-4 weeks)	**Skin/Tissue** ☐ Excision ☐ Re-Excision ☐ Punch ☐ Shave ☐ Curette		

A	B	C
Patient Name/Initials:	**Patient Name/Initials:**	**Patient Name/Initials:**
DOB:	**DOB:**	**DOB:**
Site:	**Site:**	**Site:**
To ensure processing, affix completed label to specimen container.	*To ensure processing, affix completed label to specimen container.*	*To ensure processing, affix completed label to specimen container.*

FORWARD ADDITIONAL COPY OF REPORT TO

*Dr. Name (first, last): ______________________________

*Fax: ______________________________

Required information to forward reports

Physician Signature: REQUIRED

______________________________ Date: ______________

The requested test(s) is/are medically indicated for patient management.

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.

Specimen container must include patient Name, Site and Corresponding Label.