StrataDx
1 Cranberry Hill, Suite 303
Lexington, MA 02421
Phone: 800-325-7284
Fax: 617-401-4032

Date of Procedure:_____

BILLING INFORMATION

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

PATIENT INFORMATION

Date of Birth:_____ Sex: ☐ Female ☐ Male

Name (Last, First, Middle Initial)

Address

City State Zip Code

Phone Number Medical Record Number (optional)

INSURANCE INFORMATION

Primary Medical Insurance	Secondary Medical 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	Additional Clinical Information
A	**Nail Unit Dystrophy (Fungal, Inflammatory, Neoplasm)** ☐ Nail - High Sensitivity (PAS/GMS) ☐ Nail - Low Sensitivity (PAS) ☐ Reflex to PCR, only if positive (3-4 days) ☐ Always add PCR (2 days) ☐ Reflex for Terbinafine resistance if dermatophyte positive (2 days)* ☐ Reflex to Culture, only if negative (2-4 weeks)	**Skin/Tissue** ☐ Shave ☐ Punch ☐ Curettage ☐ Excision ☐ Re-Excision		**ICD 10** (Required for PCR testing)
B	**Nail Unit Dystrophy (Fungal, Inflammatory, Neoplasm)** ☐ Nail - High Sensitivity (PAS/GMS) ☐ Nail - Low Sensitivity (PAS) ☐ Reflex to PCR, only if positive (3-4 days) ☐ Always add PCR (2 days) ☐ Reflex for Terbinafine resistance if dermatophyte positive (2 days)* ☐ Reflex to Culture, only if negative (2-4 weeks)	**Skin/Tissue** ☐ Shave ☐ Punch ☐ Curettage ☐ Excision ☐ Re-Excision		**ICD 10** (Required for PCR testing)
C	**Nail Unit Dystrophy (Fungal, Inflammatory, Neoplasm)** ☐ Nail - High Sensitivity (PAS/GMS) ☐ Nail - Low Sensitivity (PAS) ☐ Reflex to PCR, only if positive (3-4 days) ☐ Always add PCR (2 days) ☐ Reflex for Terbinafine resistance if dermatophyte positive (2 days)* ☐ Reflex to Culture, only if negative (2-4 weeks)	**Skin/Tissue** ☐ Shave ☐ Punch ☐ Curettage ☐ Excision ☐ Re-Excision		**ICD 10** (Required for PCR testing)

Not available in NY.

FORWARD ADDITIONAL COPY OF REPORT TO

Dr. Name (First, Last)*_____

Fax Number*_____

*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.

To ensure processing, affix completed label to specimen container.