Consolidated Pathology Consultants

28100 N. Ashley Cr., #106
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Patient Data				Billing Information *(Continued)*	
Name (Last, First)				Responsible Party (Last, First) Relationship to Subscriber ☐ Self ☐ Child ☐ Spouse ☐ Ot	
Patient I.D. or SSN	Office MR #			Address	Apt. No.
Date of Birth (Month, Day, Year) ☐ Male ☐ Female	Date Collected	Time Collected : ☐ A.M. ☐ P.M.		City State	Zip
Physician Signature (Required for Medicaid)	Physician Medicaid #	NPI #		Patient Phone No. ( )	
Additional Reports to: Fax:_______________________				Medicare I.D. Number	Medicare I.D. Number (Incl. Suffix)
				Primary Insurance Name and Plan	HMO Y ☐ N ☐
				Policy I.D. Number	Group No.
Billing Information:					
☐ Account	☐ Medicare	☐ Insurance	☐ Patient	Street City State	Zip
MEDICARE PATIENTS: *Please complete the Advanced Beneficiary Notice (ABN) and attach to the requisition when submitting a specimen.*					
ICD Diagnosis Codes (Enter All That Apply) ▶	①	②	③	④	

Effective 10/1/15: For ICD-10 requirements, please include site(s) and detailed clinical information available for each specimen.

Specimen site (s) **Required**	Pre/Post Op Diagnosis/Clinical Impression **Required**
1. ______________________	______________________
2. ______________________	______________________
3. ______________________	______________________
4. ______________________	______________________
5. ______________________	______________________
6. ______________________	______________________
7. ______________________	______________________
8. ______________________	______________________

9. Culture
Site(required)______________Test requested___ Aerobic ___Anaerobic ___Fungal (all white E-Swab)
Additional Information:

REPORTS & SUPPLIES (847) 996-1030

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