ANATOMICAL PATHOLOGY TEST REQUEST

Newport Harbor Pathology Medical Group

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PATIENT INFORMATION

Last name First Name MI Date of Birth M F Sex Patient Cell Phone Number Patient Social Security Number Patient Home Phone Number Street Address Apt # City State ZIP	
DIAGNOSIS: Please insert narrative diagnosis, or ICD-9 codes using the highest specificity code.	ORDERING PHYSICIAN NAME: (Please Print) NPI NUMBER: REPORT COPIES TO:

HISTORY AND CLINICAL DIAGNOSIS

BILLING INFORMATION: Attach copy of all insurance I.D. Cards (FRONT and BACK please.)

BILL TO: Patient ___ Doctor___ HMO ___ Client___ Medicare___ Medi-cal___ Auth# _____	Insured's NAME: Relationship to Insured: ____Self ____Spouse _____Dependent _____Other	Insurance Company Name: Address:
Subscriber ID #:	Subscriber Date of Birth:	City:
Subscriber Group #	Subscriber Sex: ____Male _____Female	State: ZIP

_____Medicare patient reviewed and signed Advanced Beneficiary Notice for Non-Covered Services

SPECIMENS:

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4	8

DATE Collected: _____ **TIME Collected**:_____ **COLLECTOR'S NAME:**_____