ANATOMIC PATHOLOGY REQUISITION

NEWPATH LABS

Newport Harbor Pathology Medical Group
2901 W. Coast Hwy., Suite 200, Newport Beach, CA 92663
Telephone: 949-891-1297 FAX: 949-258-4354 www.newpathlabs.com

CASE # ____________
For Lab Use Only

*** HIGHLIGHTED AREAS ARE REQUIRED**

PATIENT INFORMATION

Last Name | First Name | MI

Date of Birth | M F Sex | Patient Social Security Number

Patient Cell Phone Number | Patient Home Phone Number

Street Address | Apt #

City | State | Zip

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

BILL TO: ❑ Patient ❑ Ins. ❑ Client ❑ Medicare ❑ Medi-cal		Insured's Name:		Insurance Company Name:
Auth#		Relationship to Insured: ❑ Self ❑ Spouse ❑ Dependent ❑ Other		Address:
ID#:	Group#:	Insured's Date of Birth:	Insured's Sex: ❑ Male ❑ Female	City / State/Zip

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

HISTORY AND CLINICAL INFORMATION

SPECIMENS:

1.
2.
3.
4.
5.
6.
7.
8.

DIAGNOSIS CODE / REASON FOR PROCEDURE:

ORDERING PHYSICIAN NAME:

FACILITY:

REPORT COPIES TO:

DATE COLLECTED: ____________ **TIME COLLECTED:** ____________ **COLLECTOR'S NAME** ____________

Newport Harbor Pathology Medical Group
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