337405

Uropathology Requisition

NEWPORT HARBOR
Pathology Medical Group

One Technology Drive East
Suite C-523
Irvine, CA 92618
Ph: (949) 891-1297
Fax: (949) 625-8010

PATIENT INFORMATION: FILL OUT OR ☐ COPY OF FRONT SHEET ATTACHED

Last Name | First Name | MI | DOB (/ /)

Address | SSN

City | State | Zip | Patient ID No.

( ) Home Telephone | ( ) Work Telephone | Sex | Race

BILLING INFORMATION: FILL OUT OR ☐ COPY OF INSURANCE CARD ATTACHED

Insurance Company | Subscriber Name

Address | Policy No.

City | State | Zip | Group No.

Secondary Insurance Company | Subscriber Name

Address | Policy No.

City | State | Zip | Group No.

DOCTOR | LOCATION | DATE OF PROCEDURE (/ /20)

0500

CLINICAL INFORMATION / DIAGNOSIS CODE:

PROSTATIC NEEDLE BIOPSIES

TWELVE				SEXTANT			
0500 LEFT	0500 LEFT	0500 RIGHT	0500 RIGHT	0500 LEFT	0500 RIGHT		
0500 LEFT LATERAL BASE	0500 LEFT BASE	0500 RIGHT BASE	0500 RIGHT LATERAL BASE	0500 LEFT BASE	0500 RIGHT BASE	BILATERAL	
0500 LEFT LATERAL MID	0500 LEFT MID	0500 RIGHT MID	0500 RIGHT LATERAL MID	0500 LEFT MID	0500 RIGHT MID	0500 LEFT	0500 RIGHT
0500 LEFT LATERAL APEX	0500 LEFT APEX	0500 RIGHT APEX	0500 RIGHT LATERAL APEX	0500 LEFT APEX	0500 RIGHT APEX	0500 LEFT	0500 RIGHT

My tissue specimen(s) are being sent to the doctor(s) at NHPMG, PC, for diagnosis. I authorize the holder of medical or other information about me to release information that has to do with diagnosing my tissues, and with the billing and payment for those services, to parties that have medical and/or financial involvement in those processes. I authorize payment to Biopsy Diagnostics, PC, for those services. If Medicare or my private health insurance denies payment for some or all of the services, then I accept responsibility for any remaining balances.

Patient's Signature / Date

Yellow Copy - Billing Copy - Return with container White Copy – Return with container Pink – Keep for your records