GOPATH®
LABORATORIES
Global Pathology Services

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www.gopathlabs.com

# DermPath Requisition

## Ordering Physician / Laboratory Information

Physician Name ______________________
NPI# ______________________
Address ______________________
City, State, Zip ______________________
Phone # ______________ Fax # ______________
Physician's Signature ______________________
Date of Service ______________________

## Patient Information *(Please Print)*

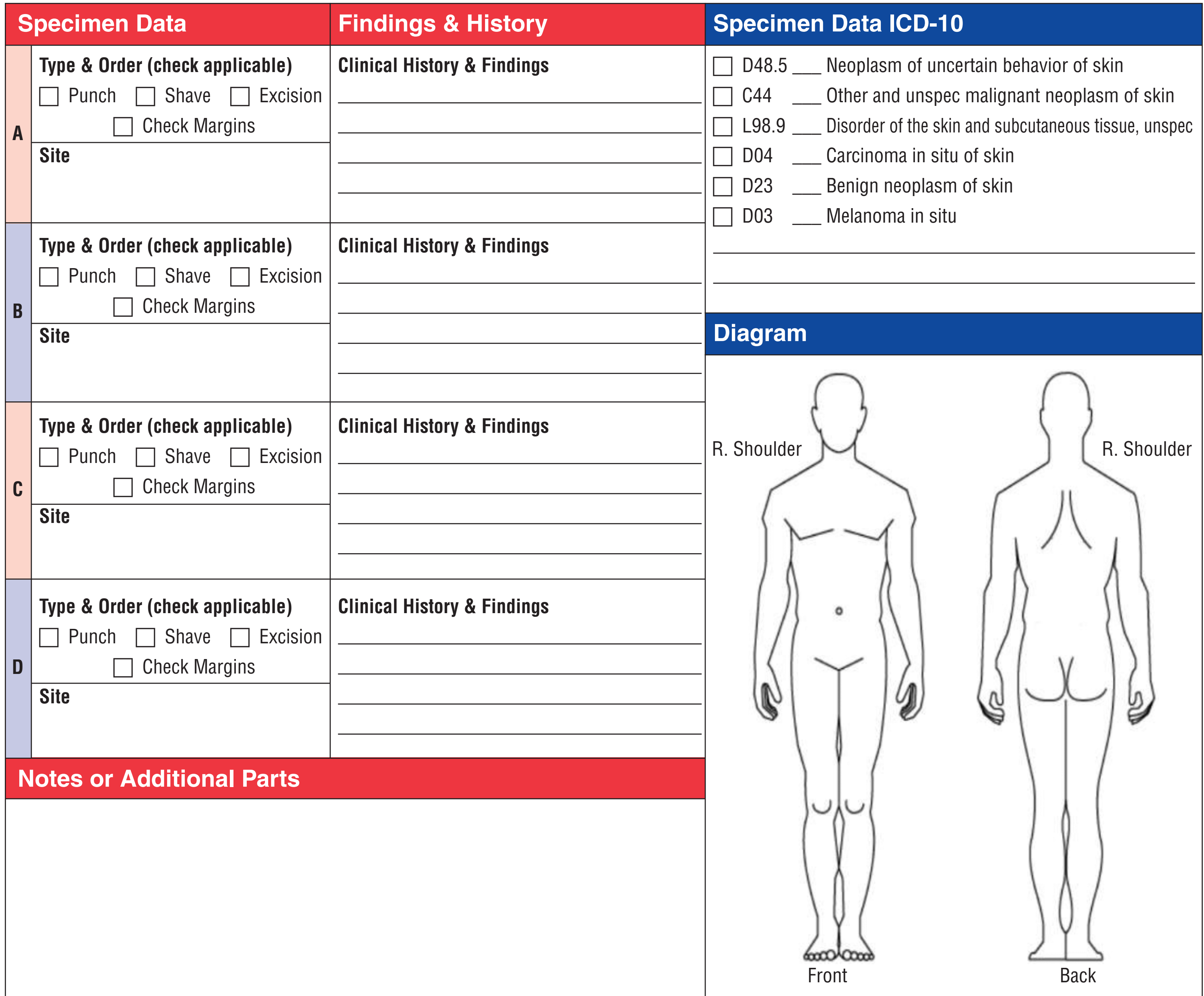
Name (Last, First) ______________________
Address ______________________
City, State, Zip ______________________
☐ Female ☐ Male Date of Birth (M/D/Y) ______________
SSN # ______________________
Patient ID # ______________ Phone # ______________

## Billing Information *(Please provide copy of insurance card.)*

Primary Insurance: ______________________
Secondary Insurance: ______________________

## Place of Service

☐ 11–Office ☐ 21–Inpatient Hospital
☐ 22–Outpatient Hospital ☐ 24–Ambulatory Surgery Center



## Specimen Data

| | Specimen Data | Findings & History |
|---|---|---|
| A | **Type & Order (check applicable)**<br>☐ Punch ☐ Shave ☐ Excision<br>☐ Check Margins<br>**Site** | **Clinical History & Findings** |
| B | **Type & Order (check applicable)**<br>☐ Punch ☐ Shave ☐ Excision<br>☐ Check Margins<br>**Site** | **Clinical History & Findings** |
| C | **Type & Order (check applicable)**<br>☐ Punch ☐ Shave ☐ Excision<br>☐ Check Margins<br>**Site** | **Clinical History & Findings** |
| D | **Type & Order (check applicable)**<br>☐ Punch ☐ Shave ☐ Excision<br>☐ Check Margins<br>**Site** | **Clinical History & Findings** |

## Specimen Data ICD-10

☐ D48.5 ___ Neoplasm of uncertain behavior of skin
☐ C44 ___ Other and unspec malignant neoplasm of skin
☐ L98.9 ___ Disorder of the skin and subcutaneous tissue, unspec
☐ D04 ___ Carcinoma in situ of skin
☐ D23 ___ Benign neoplasm of skin
☐ D03 ___ Melanoma in situ

## Diagram



## Notes or Additional Parts

To view reports, please visit www.gopathlabs.com and click Online Reporting.

**A. Notifier:**

**B. Patient Name:** **C. Identification Number:**

# Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for **D.** ____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ____________ below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| | | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ____________ listed above.
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

| G. OPTIONS: **Check only one box. We cannot choose a box for you.** |
|---|
| ☐ **OPTION 1.** I want the **D.** ____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. |
| ☐ **OPTION 2.** I want the **D.** ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**. |
| ☐ **OPTION 3.** I don't want the **D.** ____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.** |

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.