South Bend Medical Foundation
530 North Lafayette Boulevard
South Bend, IN 46601-1098

Client Code: ( ) Name: _____

✓ Dr # Physician's Last Name, First Name

[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____

DERMATOPATHOLOGY REQUISITION

J.L. Simpson MD
Medical Director

SIGNATURE OF ORDERING PROVIDER
(Signature must be dated, legible, and include first and last name)

_____

DATE_____

CONSULTING PHYSICIAN (First and Last Name)

_____

BILLING

☐ PHYSICIAN / ACCOUNT
☐ PATIENT / INSURANCE
(SEE REVERSE)
☐ BCCP, ALPHA ID #_____

IF NO BILLINGINFORMATION IS PROVIDED AND NO BOX IS CHECKED, YOUR ACCOUNT WILL BE BILLED.

PATHOLOGY USE ONLY
ACCESSION #
(place label here)

PATIENT INFORMATION

Name _____ DOB_____ AGE _____ SEX _____
Last First MI MO / DAY / YEAR

Patient Address _____ City, State, ZIP code _____

SSN _____ MRN _____ ☐ Inpatient ☐ Outpatient

CLINICAL INFORMATION

SPECIMEN 1

Date of Collection _____
Time of Collection _____
☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Clinical Findings:

Differential Diagnosis:

SPECIMEN 2

Date of Collection _____
Time of Collection _____
☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Clinical Findings:

Differential Diagnosis:

SPECIMEN 3

Date of Collection _____
Time of Collection _____
☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Clinical Findings:

Differential Diagnosis:

SPECIMEN 4

Date of Collection _____
Time of Collection _____
☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Clinical Findings:

Differential Diagnosis:

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For our locations and hours
please visit our website @
www.sbmf.org or call us at
574-234-4176 and press 5
800-544-0925 and press 5

INSURANCE INFORMATION

Responsible Party Name (required if patient is a minor):

Responsible Party Address:

City | State | Zip

Responsible Party Phone

( ) _____ - _____

☐ Medicare # _____

☐ Medicaid # _____ EDD _____
M/D/Y _____

☐ Primary Insurance (Complete or attach copy of insurance card.)

INSURANCE COMPANY NAME:		
NETWORK:		
CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:
POLICY HOLDER NAME:		D.O. B.
RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent		
POLICY ID #:	GROUP #:	
EMPLOYER:	EFFECTIVE DATE:	

☐ Secondary Insurance (Complete or attach copy of insurance card front & back.)

INSURANCE COMPANY NAME:		
NETWORK:		
CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:
POLICY HOLDER NAME:		D.O. B.
RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent		
POLICY ID #:	GROUP #:	
EMPLOYER:	EFFECTIVE DATE:	

IMPORTANT

A WRITTEN ORDER AND AN APPROPRIATE DIAGNOSIS MUST ACCOMPANY EACH LABORATORY TEST. WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, ONLY TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT SHOULD BE ORDERED.

MICROBIOLOGY PROTOCOL

MICROBIOLOGY CULTURES MAY INCLUDE CHARGES FOR ONE PRIMARY SOURCE SMEAR, ONE PRIMARY CULTURE, ONE CHARGE PER ORGANISM REQUIRING IDENTIFICATION, AND ONE CHARGE PER SENSITIVITY PERFORMED. This is source specific. Refer to the fee schedule for further clarification, or call The Medical Foundation Client Services Department at (574) 236–7263 or (800) 950-7263

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

EVERY patient MUST read, sign, and date:

I request that payment of authorized Medicare or insurance benefits be made on my behalf to the South Bend Medical Foundation.

I authorize any holder of medical or other information about me to release to my designated insurance company, Centers for Medicare and Medicaid Services (CMS), and their agents, information to determine payable benefits for related services.

I agree that I am fully responsible for the payment of all the designated laboratory services South Bend Medical Foundation rendered to me or on my behalf. I accept responsibility for charges Medicaid does not cover when I am enrolled in a limited coverage Medicaid program.

I understand that additional testing may be performed based on my physician's request. I agree to be fully responsible for payment if my insurance plan does not cover the cost.

I also agree that if any insurance plan, except Medicaid, determines the tests requested to be medically unnecessary, and/or uncovered procedures, and denies payment to the South Bend Medical Foundation, I accept full responsibility for payment to South Bend Medical Foundation.

_____ Patient Signature

_____ Date