UCLA Dentistry
Oral Pathology Lab

Lab Use Only

LAB#

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TISSUE EXAMINATION REQUEST FORM

NOTE: We ***cannot*** process any specimen from a Medicare eligible patient unless the submitting doctor is registered with Medicare via PECOS system.

PATIENT INFORMATION *(Please Print Complete Information):*

Last Name **First Name**

Date of Birth **Social Security Number / MEDICARE PATIENTS! PROVIDE MEDICARE SUBSCRIBER#**

Sex: ☐ Male ☐ Female

Address

City **State** **Zip**

Home Phone #: (_____)_____-_____ **Work Phone #:** (_____)_____-_____

BILLING INFORMATION *(Must Be Completed): NOTE: WE CANNOT BILL DOCTORS (CA Business & Professions Code 655.7)*

☐ Bill Patient
☐ MEDICARE # SEE ABOVE REQUIREMENT! (attach copy of card)
☐ MEDI-CAL # _____(attach copy of card)
☐ *Bill Responsible Party Other Than Patient (provide information below)
☐ Secondary Insurance (provide details below & copy of card)
☐ Dental/Medical Insurance (provide details below & copy of card)

Primary Insurance: _____Insured Name_____
Address: _____ City_____ State_____ Zip_____
Subscriber #: _____-_____-_____ Group #: _____ DOB: _____/_____/_____

Secondary Insurance: _____Insured Name_____
Address: _____ City_____ State_____ Zip_____
Subscriber #: _____-_____-_____ Group #: _____ DOB: ____/____/_____

Responsible Party (if other than patient): *NOTE: WE CANNOT BILL DOCTORS (CA Business & Professions Code 655.7)*
Last Name_____ First Name_____ Phone #: (_____)_____-_____
Address: _____ City_____ State_____ Zip_____
DOB: _____/_____/_____ SSN: _____-_____-_____
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian ☐ Other:_____

SUBMITTING DOCTOR'S INFORMATION *(Must Be Completed):*

Name: _____
Address: _____Suite#:_____
City: _____ State: _____ Zip: _____
Phone: (_____)_____-_____ Fax: (_____)_____-_____

If requesting faxed results, please provide fax #
(_____)_____-_____

Please send____formalin bottles/forms

Medicare cases. Doctor registered as: Prescribed/ Refer ☐ **Opt Out** ☐ **Provider** ☐

Doctor's NPI#: _____

MUST COMPLETE BACK PAGE!

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Complete front page!

Patient Name:_____

Date of procedure:_____/_____/_____

SPECIMEN INFORMATION (Must Be Completed):

Clinical Diagnosis_____

Biopsy Location_____

History_____

_____

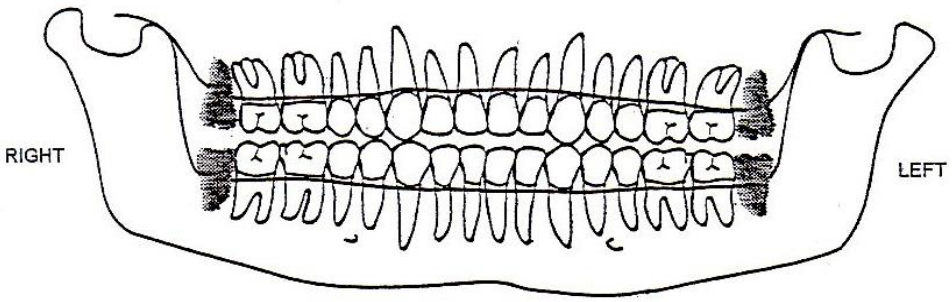
_____

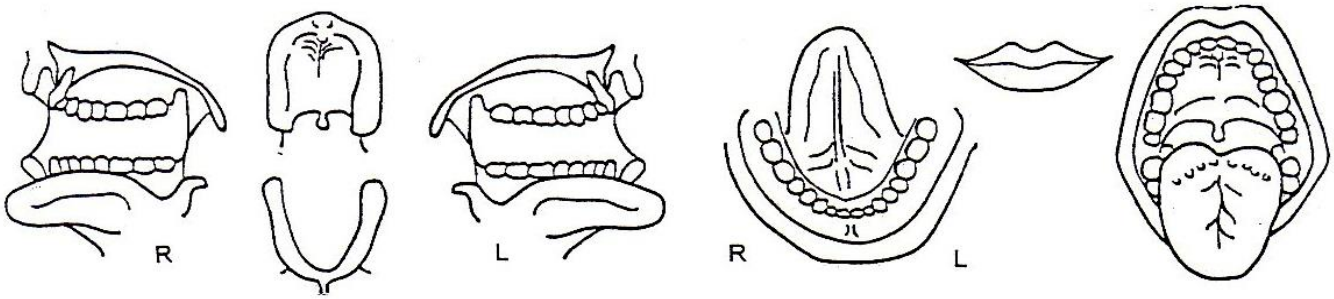
_____

_____

Radiographs / Photos submitted? ☐ No ☐ Yes ☐ Please Return

Previous specimens sent to UCLA Oral Pathology on this patient? ☐ No ☐ Yes Previous Lab #:_____





Lab Use Only **Number of specimen/formalin bottles received: 1 2 3 4 5** _____

GR1 GR2 GR3 GR4 GR5 GR6 GR7 GR8 GHS Other_____

GRA GRB GRC GRD GRE GRF GRG GRH GSC Other_____