UCLA Dentistry
Oral Pathology Lab

Laboratory Number:_____

YI-LING LIN, DDS, DMSC, DIRECTOR
NPI#: 199-276-6000

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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.
Note, incomplete or missing information will delay or prevent processing of the specimen.

PATIENT INFORMATION *(Please Print Complete Information):*

Last Name **First Name**

Date of Birth **Sex:** ☐ Male ☐ Female

Social Security Number / MEDICARE PATIENTS! PROVIDE MEDICARE SUBSCRIBER#

Address

City **State** **Zip**

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

NOTE: COPY OF PATIENT PHOTO ID / PARENT/GUARDIAN PHOTO ID REQUIRED!

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

☐ Bill Patient (Attach Photo ID / Parent Guardian Photo ID
☐ MEDICARE # SEE ABOVE REQUIREMENT! (attach copy of card & Photo ID)
☐ MEDI-CAL # _____ (attach copy of card & Photo ID)
☐ *Bill Responsible Party (Parent/Guardian & attach Photo ID)
☐ Secondary Insurance (attach copy of card & Photo ID)
☐ Dental/Medical Insurance (attach copy of card & Photo ID)

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 NOTE: PHOTO ID REQUIRED: ☐ Spouse ☐ Parent ☐ Guardian ☐ Other:_____

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

Name: _____
Address: _____Suite#:_____
City: _____ State: _____ Zip: _____
Phone: (_____)_____-_____ Fax: (_____)_____-_____ Please send_____ formalin kits

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

Doctor's NPI#: _____ **Email:**_____

MUST COMPLETE BACK PAGE!

Laboratory Number: _____

Complete the front page!

Patient Name:_____

Date of procedure:_____/_____/_____

SPECIMEN INFORMATION (Must Be Completed):

Clinical Diagnosis_____

Biopsy Location_____

History_____

_____

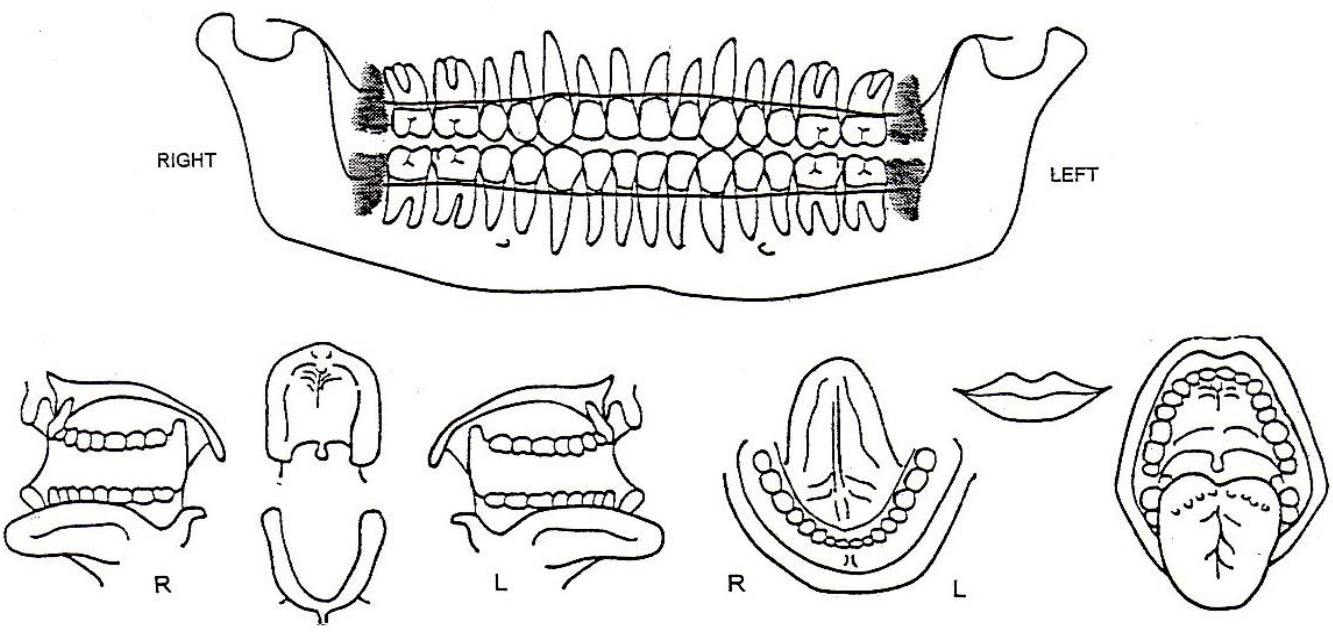
_____

_____

_____

Radiographs / Photos submitted? ☐ No ☐ Yes

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_____