Specimen collection Date: Time:	HIS Label	LIS Label

ALBANY MEDICAL CENTER

Department of Pathology

43 New Scotland Avenue
Albany, New York 12208
(518) 262-5454

NAME:	**DOB:**	**SEX:**
ADDRESS:		
ADDRESS:	**MR#/SS#:**	
PRIMARY INSURANCE CO.:	**PLAN NAME:**	
SUBSCRIBER:	**RELATIONSHIP TO SUBSCRIBER:**	
ID#:	**GROUP #:**	
SECONDARY INSURANCE CO.:	**PLAN NAME:**	
SUBSCRIBER:	**RELATIONSHIP TO SUBSCRIBER:**	
SUB. DOB: **SUB. SEX:**	**ID#**	**GROUP #:**

DIAGNOSIS / ICD 10 CODES
MANDATORY FOR EACH TEST ORDERED

1.	2.	3.

NOTIFICATION TO PHYSICIANS AND OTHER PERSONS LEGALLY AUTHORIZED TO ORDER TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT:

MEDICARE WILL ONLY PAY FOR TESTS THAT MEET THE MEDICARE COVERAGE CRITERIA AND ARE REASONABLE AND NECESSARY TO TREAT OR DIAGNOSE AN INDIVIDUAL PATIENT. MEDICARE DOES NOT PAY FOR TESTS FOR WHICH DOCUMENTATION, INCLUDING THE MEDICAL RECORD, DOES NOT SUPPORT THAT THE TESTS WERE REASONABLE AND NECESSARY. MEDICARE GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS EVEN IF THE PHYSICIAN OR OTHER AUTHORIZED PRACTITIONER CONSIDERS THE TESTS APPROPRIATE FOR THE PATIENT.

DERMATOPATHOLOGY AND IMMUNODERMATOLOGY

SPECIMEN TYPE AND INSTRUCTIONS

Circle specimen type. Use extra sheets if more than 3 specimens are sent.

SPECIMEN A:	Curettage	**SITE**	**Clinical Findings and Diagnosis**
Punch Bx	Check Margins		
Shave Bx	Alopecia Sections		
Snip Bx	Slide Consultation		
Incisional Bx	DIF Involved Skin		
Excisional Bx	DIF Uninvolved Skin		
Excision	Indirect Immuno		

SPECIMEN B:	Curettage	**SITE**	**Clinical Findings and Diagnosis**
Punch Bx	Check Margins		
Shave Bx	Alopecia Sections		
Snip Bx	Slide Consultation		
Incisional Bx	DIF Involved Skin		
Excisional Bx	DIF Uninvolved Skin		
Excision	Indirect Immuno		

SPECIMEN C:	Curettage	**SITE**	**Clinical Findings and Diagnosis**
Punch Bx	Check Margins		
Shave Bx	Alopecia Sections		
Snip Bx	Slide Consultation		
Incisional Bx	DIF Involved Skin		
Excisional Bx	DIF Uninvolved Skin		
Excision	Indirect Immuno		

Has the patient had any prior biopsies at AMC? ☐ No ☐ Yes If Yes When? _____

Ordering practitioner: _____ (print first and last name) MD / PA / NP (circle one)

Ordering practitioner: _____ (signature) MD / PA / NP (circle one)

Ordering practitioner contact #: _____

If ordering is PA, NP, or Resident:
Supervising physician is REQUIRED _____ (print first and last name)

Copy To: _____ (print first and last name)

Copy To (Phone #): _____

Copy to (Fax #): _____

Copy To (Address): _____