PROFESSIONAL PATHOLOGY OF WYOMING

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Anatomical Pathology Specimen Requisition

_____-_____-_____ Patient's Social Security #

____/____/_____ Date of Birth:

Collection Date: ____/____/_____

Submitting Physician:

_____ Name / Practice

_____ Street Address

_____ City _____ State _____ Zip

_____ City _____ State

_____ Zip _____-_____-_____ Phone

_____-_____-_____ Fax

Bill To:

Self-Pay *(Patient)*

Facesheet attached

Medicare# _____

Medicaid# _____

Primary Insurance Relationship _____

_____ Insurance Co. Name *(Please send copy of card)*

_____ Street Address

_____ City _____ State _____ Zip

_____ Policy # _____ Group #

_____ Patient Last Name / First Name / Middle Name

_____ Street Address

_____ City _____ State _____ Zip

Male Female Gender

_____-_____-_____ Patient Phone #:

_____ Guarantor Last / First Name: *(If different from Patient)*

_____ Street Address*(If different from Patient)*

_____ City _____ State _____ Zip

Self Parent Spouse Guardian Other:_____

Guarantor Relationship to Patient

Secondary Insurance Relationship _____

_____ Insurance Co. Name *(Please send copy of card)*

_____ Street Address

_____ City _____ State _____ Zip

_____ Policy # _____ Group #

	Specimen Source	Laterality	Anatomic Location	Procedure	ICD Codes
A	Lung, Skin	Left, Right	Upper, Lower, Lobe, Forehead	Biopsy, Excision	R87.610
B	Lung, Skin	Left, Right	Upper, Lower, Lobe, Forehead	Biopsy, Excision	R87.610
C	Lung, Skin	Left, Right	Upper, Lower, Lobe, Forehead	Biopsy, Excision	R87.610
D	Lung, Skin	Left, Right	Upper, Lower, Lobe, Forehead	Biopsy, Excision	R87.610
E	Lung, Skin	Left, Right	Upper, Lower, Lobe, Forehead	Biopsy, Excision	R87.610
F	Lung, Skin	Left, Right	Upper, Lower, Lobe, Forehead	Biopsy, Excision	R87.610
G	Lung, Skin	Left, Right	Upper, Lower, Lobe, Forehead	Biopsy, Excision	R87.610
H	Lung, Skin	Left, Right	Upper, Lower, Lobe, Forehead	Biopsy, Excision	R87.610

Clinical Data/ Previous Therapy/ Pre-Operative and/or Post-Operative Diagnosis

Accession #: *Lab Use Only*