ORAL & MAXILLOFACIAL REQUISITION

CLIA ID # 31D2026917

PATIENT INFORMATION - ALL REQUIRED

Date of Collection: ____________________ Time of Collection: ____________________
Last Name: __________________________ First Name: ________________ MI: ______
Cell #: ______________________________ Email: ______________________________
Home #: ____________________________ Street Address: _______________________
Apt: ________ City: _______________________________ State: _____ Zip: _________
DOB: (MM/DD/YYYY): _______ / _______ / _____________ SSN #: _________________
(SSN # required for uninsured patients only)

Gender Identity and Sexual Orientation

- ☐ Male
- ☐ Female
- ☐ Non-Binary/Genderqueer
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Lesbian, Gay or Homosexual
- ☐ Bisexual
- ☐ Other: ____________________

Race and Ethnicity - Select all that apply

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Choose not to disclose
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Other: ____________

Guidelines for patient demographics are provided by NJDOH/CLIS (NJSA 45:9-42.46 to -42.49)

REFERRING PHYSICIAN INFO. (Required)

INSURANCE INFO. (Required)

Policyholder Name: ________________________________
Insurance Name: __________________________________
Policy #: __________________________
Group #: __________________________

- ☐ Bill Insurance
- ☐ Bill Client
- ☐ Self Pay

Please provide a copy of the front & back of insurance card(s).

SPECIMEN ID: T128353

LAB ACCESSION #: ____________

PATIENT HISTORY

____ ☐ Immunology

ICD-10 CODES

- ☐ Benign Mucosal Lesion K13.70
- ☐ Benign Mucosal Neoplasm D10.30
- ☐ Leukoplakia K13.21
- ☐ Erythroplakia K13.29
- ☐ Lichen Planus L43.8
- ☐ Oral Melanotic Macule L81.9
- ☐ Amalgam Tattoo M79.5
- ☐ Hemangioma D18.09
- ☐ Sinusitis J32.9
- ☐ Mucocele K11.6
- ☐ Sialadeniti K11.20
- ☐ Foreign Body Granuloma T18.0XXA
- ☐ Radicular Cyst K04.8
- ☐ Dentigerous, OKC K09.0
- ☐ Torus/ Exostosis M27.8
- ☐ Osteitis/Sequestrum/Osteomyelitis M27.2
- ☐ Other: ____________________________

TYPE OF BIOPSY

	Biopsy	POST-OP DIAGNOSIS
A	Location ____________ Size: ____________ Description of Lesion: ____________ ☐ Incisional ☐ Excisional ☐ Punch ☐ Curette ☐ Cytologic Smear Other ____________	
B	Location ____________ Size: ____________ Description of Lesion: ____________ ☐ Incisional ☐ Excisional ☐ Punch ☐ Curette ☐ Cytologic Smear Other ____________	
C	Location ____________ Size: ____________ Description of Lesion: ____________ ☐ Incisional ☐ Excisional ☐ Punch ☐ Curette ☐ Cytologic Smear Other ____________	
D	Location ____________ Size: ____________ Description of Lesion: ____________ ☐ Incisional ☐ Excisional ☐ Punch ☐ Curette ☐ Cytologic Smear Other ____________	
E	Location ____________ Size: ____________ Description of Lesion: ____________ ☐ Incisional ☐ Excisional ☐ Punch ☐ Curette ☐ Cytologic Smear Other ____________	

BOTH PATIENT AND PHYSICIAN MUST SIGN to approve testing

By signing below, I confirm I have read the ABN on the reverse side.

Patient Signature: ______________________________

I authorize the release of medical information related to services provided herein to my health plan/ insurance carrier and authorize payment directly to QDx Pathology Services and/or lab services provider. I assume responsibility for payment of charges not covered by my healthcare insurer.

Physician Signature: ______________________________

CMS requires physician signature on all requisitions. QDx Pathology Services is responsible for verifying signature prior to performing testing.

300 Columbus Circle, Suite A, Edison, NJ 08837 | Tel: (866) 909-PATH | Fax: (908) 272-1478 | www.qdxpath.com

T128353 SITE ________ NAME ________	T128353 SITE ________ NAME ________	T128353 SITE ________ NAME ________	T128353 SITE ________ NAME ________	T128353 SITE ________ NAME ________
T128353 SITE ________ NAME ________	T128353 SITE ________ NAME ________	T128353 SITE ________ NAME ________	T128353 SITE ________ NAME ________	T128353 SITE ________ NAME ________

Notifier(s):

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Non coverage (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Laboratory Tests	Reason Medicare May Not Pay	Estimated Costs

What you need to do now:

- Read this notice, so you can make an informed decision about your care
- Ask us any questions that you may have after you finish reading
- Choose an option below about whether to receive the checked items listed in the first box above

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1**: I want the Laboratory Test(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2:** I want the Laboratory Test(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3:** I do not want the Laboratory Test(s) listed above, I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.