

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Male | <input type="checkbox"/> Transgender Male | <input type="checkbox"/> Straight or Heterosexual |
| <input type="checkbox"/> Female | <input type="checkbox"/> Transgender Female | <input type="checkbox"/> Lesbian, Gay or Homosexual |
| <input type="checkbox"/> Non-Binary/Genderqueer | <input type="checkbox"/> Choose not to disclose | <input type="checkbox"/> Bisexual |
| | | <input type="checkbox"/> Other: _____ |

Race and Ethnicity - Select all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> White | <input type="checkbox"/> Non-Hispanic or Latino |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> Choose not to disclose | <input type="checkbox"/> Other: _____ |

Guidelines for patient demographics are provided by NJDOH/CLIS (NJS A 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 #:

CLINICAL HISTORY / ICD-10 CODES

IMPORTANT: PLACE APPROPRIATE LABEL ON SPECIMEN. WRITE SPECIMEN SITE ON BLANK LABELS. LABELS ARE NUMBERED AND SPECIFIC FOR EACH FORM. DO NOT INTERCHANGE.

TYPE OF BIOPSY

					ICD-10
A	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	Other _____	
B	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	Other _____	
C	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	Other _____	
D	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	Other _____	
E	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	Other _____	
F	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	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: _____

Physician 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.

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 Noncoverage (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.

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:
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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.

Form CMS-R-131 (03/11)