Knowledge from people who care

Sabaneta Industrial Park A-234 Ponce, P.R. 00716
Tel. (787) 841-8645 Fax. (787) 843-3464 / Lic. 809B/1155

LAB. NUMBER:

SURGICAL PATHOLOGY REQUISITION

PATIENT INFORMATION

Patient Name: ______________________ Age: ________

Gender: ◯F ◯M DOB: (mm/dd/yy) ___/___/___ SS No.: (Last 4 digits only) ________

Postal Address: ______________________

Phone No: ______________ Record Number: ______________

Collection Date: / / (mm/dd/yy)

Collection Time: : AM PM

Time FixativeAdded: : AM PM

BILLING INFORMATION (Please provide copy of insurance card)

Bill to: ◯ Client ◯ Insurance ◯ Patient ICD 9/10 CODE: ______________

Health Insurance: ____________ Insurance Contract No.: ____________ Group No.: ________

CLINICAL INFORMATION

Source of Specimen: ______________________

PRE- OP Dx: ______________________

POST- OP Dx: ______________________

Clinical History: ______________________

Physicians Name: ______________________

Physicians Address: ______________________

Physicians Signature: ______________________ Date: (mm/dd/yy) ____________

Yo autorizo a mi médico a proveer información a Southern Pathology Services para propósitos de facturación a mi Plan Médico. De mi plan médico no cubrir la(s) prueba(s) de patología, me hago responsable del costo ya sea del deducible o el costo total de la(s) prueba(s).

I authorize my physician to provide information to Southern Pathology Services for billing my medical insurance plan. I will be responsible for the deductible or total cost of test(s) if my medical insurance determines it is a non-covered service.

Patient Signature: ______________________ **Date:** ____________ (mm/dd/yy)

This SLIP REQUEST is confidential and contains privileged information. Inappropriate disclosure is prohibited by law.
If by accident you receive this request, please contact us immediately at 787-841-8645