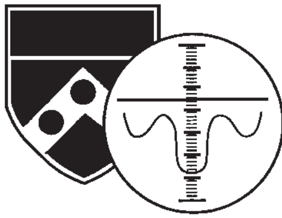

UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEMS
PENN CUTANEOUS PATHOLOGY SERVICES

3020 Market Street, Suite 201, Philadelphia, PA 19104

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Faizan Alawi, D.D.S.

HUP DERM
- ☐ Clinic
- ☐ Radnor
- ☐ 10 Penn Tower

Toll Free 866-DERMLAB (337-6522) **Customer Service (215) 662-2597**
Customer Service Fax (215) 614-0640 **Lab Fax (215) 662-6150**

PLEASE PRINT ALL INFORMATION BELOW

Last Name	First Name	Biopsy Date	Accessioner			
			Race	Sex	Birth Date	Marital Status

Address

City | State | Zip Code

Last 4 digits of SS # | Home Telephone ( ) | Day Telephone ( )

Previous Biopsy Number and Date for Same Condition

Clinical Description of Lesion(s)

☐ Urgent/Rush Status (provisional diagnosis by phone)

☐ **Alopecia - Horizontal Sectioning**

Precautions (AIDS, Hepatitis, specify):

Special Handling/Orientation (specify):

LAB USE ONLY
Please do not write in box below.

Slide Number	Date Received

Gross Descriptions
A)
B)
C)
D)
E)

Anatomical Source/Clinical Diagnosis of Specimens

	Anatomical Source	Clinical ICD-9	Clinical ICD-9 Description		
A	____	/ ____	/ ____	☐ Punch ☐ Margin Required	☐ Shaved ☐ Curetted ☐ Excised
B	____	/ ____	/ ____	☐ Punch ☐ Margin Required	☐ Shaved ☐ Curetted ☐ Excised
C	____	/ ____	/ ____	☐ Punch ☐ Margin Required	☐ Shaved ☐ Curetted ☐ Excised
D	____	/ ____	/ ____	☐ Punch ☐ Margin Required	☐ Shaved ☐ Curetted ☐ Excised

Pathological Diagnosis

Submitting Physician | Telephone

BILLING INFORMATION (MUST BE COMPLETED - SEE REVERSE)

AUTHORIZATIONS
ALL PATIENTS

Patient Name ____________________ Patient Identification Number ____________________

“I hereby assign payment of medical benefits directly to the University of Pennsylvania Health System for such services as may be provided to me or my dependent.”

“I authorize the release of any medical information necessary to any insurance company or public agency and its agents with whom I have coverage, to determine benefits for services provided to me or my dependent. In case of Medicare benefits, I authorize any holder of medical information about me, to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable to related services.”

“I understand that this authorization may not result in full payment by my insurance carrier of the charges for which I am financially responsible. I also permit a copy of the authorization to be used in place of the original.”

I have read and agree with the above statements.

Signature ____________________ Date ____________________

MANAGED CARE FINANCIAL RESPONSIBILITY WAIVER

If you have an HMO or any managed care plan that requires a referral when referred to a participating specialist or hospital, you must have a referral form or authorization, given by your primary care physician, at the time of your visit. Your managed care plan does not allow referrals to be authorized after your visit. **Except in an emergency, please do not have any health care services without first obtaining a referral or authorization from your insurance plan. (Without a referral or authorization, you are not financially covered under your insurance policy and will be financially responsible for payment of services not covered by your insurance carrier.)** I have read and understood the above guidelines.

Patient/Guarantor Signature ____________________ Date ____________________

INSURANCE INFORMATION

PLEASE SUPPLY REQUIRED INFORMATION BELOW

If you have Blue Shield, Medicare or Medical Assistance, fill out the appropriate information below SECTION A
All other health insurance information fill out SECTION B

Please include a copy of the front and back of the member's insurance card and attach it to this form.

SECTION A

BLUE SHIELD
Is Blue Shield Primary? ☐ YES ☐ NO
Is Blue Shield Secondary? ☐ YES ☐ NO

MEDICAL ASSISTANCE

PLAN CODE	INSURANCE TELEPHONE NO.	GROUP NO.	IDENTIFICATION NO	EFFECTIVE DATE

SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER

RECIPIENT NUMBER	CARD ISSUE NUMBER	MANAGED CARE/MEDICAL ASSISTANCE PLAN NAME	IDENTIFICATION NUMBER

Medicare

MEDICARE NO.	MEDICARE SUPPLEMENTAL/65 SPECIAL
	PLEASE COMPLETE SECONDARY HEALTH INSURANCE (SECTION B) BELOW

IS MEDICARE PRIMARY	☐ YES	☐ NO	DO YOU OR YOUR SPOUSE HAVE OTHER INSURANCE?	☐ YES	☐ NO
IS MEDICARE SECONDARY	☐ YES	☐ NO	ARE YOU DISABLED OR HAVE END STAGE RENAL DISEASE?	☐ YES	☐ NO
TRAVELERS/RAILROAD	☐ YES	☐ NO	IS ILLNESS/INJURY THE RESULT OF AN AUTO ACCIDENT?	☐ YES	☐ NO
ARE YOU OR YOUR SPOUSE EMPLOYED?	☐ YES	☐ NO	DID ILLNESS/INJURY OCCUR AT WORK?	☐ YES	☐ NO

SECTION B

PRIMARY HEALTH INSURANCE
IS THIS AN HMO? ☐ YES ☐ NO
Please Provide Referrals and Primary Care Physicians Info.

INSURANCE CO. NAME		INSURANCE CO. ADDRESS (STREET, CITY, STATE, ZIP)		
INSURANCE CO. TELEPHONE	PLAN CODE	GROUP NO.	IDENTIFICATION NO	EFFECTIVE DATE
SUBSCRIBER NAME		SUBSCRIBER DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER	
SUBSCRIBER SSN #		PLAN TYPES ☐ POS ☐ HMO ☐ PPO ☐ OTHER (Please Describe)		
EMPLOYER NAME		EMPLOYER ADDRESS (STREET, CITY , STATE, ZIP)		
PRIMARY CARE PHYSICIAN		PCP TELEPHONE	CAPITATED LAB	

SECONDARY HEALTH INSURANCE
IS THIS AN HMO? ☐ YES ☐ NO
Please Provide Referrals and Primary Care Physicians Info.

INSURANCE CO. NAME		INSURANCE CO. ADDRESS (STREET, CITY, STATE, ZIP)		
INSURANCE CO. TELEPHONE	PLAN CODE	GROUP NO.	IDENTIFICATION NO	EFFECTIVE DATE
SUBSCRIBER NAME		SUBSCRIBER DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER	
SUBSCRIBER SSN #		PLAN TYPES ☐ POS ☐ HMO ☐ PPO ☐ OTHER (Please Describe)		
EMPLOYER NAME		EMPLOYER ADDRESS (STREET, CITY , STATE, ZIP)		
PRIMARY CARE PHYSICIAN		PCP TELEPHONE	CAPITATED LAB	