SEPA Labs
SOUTHEASTERN PATHOLOGY ASSOCIATES

Dermatopathology Request

Phone: (888) 261-2671 www.sepalabs.com
CLIA ID # 11D0691449
CAP Accredited Laboratory

Requisition #9000000

Date of Service: _____ Time Collected: _____ A.M. P.M. Requesting Physician: _____

PATIENT INFORMATION BILL TO ❑ OFFICE/CLIENT ❑ PATIENT ❑ INSURANCE ❑ MEDICARE ❑ MEDICAID

NAME			DOB	SEX	SSN
ADDRESS			CITY	STATE	ZIP
HOME PHONE	WORK PHONE		RESPONSIBLE PARTY		RELATIONSHIP
MEDICARE NUMBER				MEDICAID NUMBER	
PRIMARY INSURANCE		POLICY NUMBER		GROUP NUMBER	
SECONDARY INSURANCE		POLICY NUMBER		GROUP NUMBER	
SUBSCRIBER NAME		POLICY NUMBER		GROUP NUMBER	
INSURANCE ADDRESS		POLICY NUMBER		GROUP NUMBER	

Patient/Chart Number Date

ICD-9 Diagnosis Code(s)

Please provide a diagnosis code for all tests ordered that can be substantiated by the patient's medical record. Tests deemed not "MEDICALLY NECESSARY" must be accompanied by a signed ADVANCED BENEFICIARY NOTICE (ABN) See back of page for ABN.

*PROVIDING SS# & D.O.B. IS ESSENTIAL TO LOCATE AND REVIEW PREVIOUS HISTOLOGY AND CYTOLOGY.

Specimen	Type	M	Site/Clinical Information	Specimen	Type	M	Site/Clinical Information
A Name _____ 9000000	S E P O		**A**	**H** Name _____ 9000000	S E P O		**H**
B Name _____ 9000000	S E P O		**B**	**I** Name _____ 9000000	S E P O		**I**
C Name _____ 9000000	S E P O		**C**	**J** Name _____ 9000000	S E P O		**J**
D Name _____ 9000000	S E P O		**D**	**K** Name _____ 9000000	S E P O		**K**
E Name _____ 9000000	S E P O		**E**	**L** Name _____ 9000000	S E P O		**L**
F Name _____ 9000000	S E P O		**F**	**M** Name _____ 9000000	S E P O		**M**
G Name _____ 9000000	S E P O		**G**	**N** Name _____ 9000000	S E P O		**N**

P.E.T. Godbey, M.D., FCAP LABORATORY DIRECTOR

S= Shave E= Ellipse P= Punch O= Other M= Margins Check margins if required White Copy – Lab Yellow Copy – Client