Mammocore

A Division of Interscope Pathology Medical Group
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Manager of Client Services
Zin Htway

TEST REQUEST

Date Collected: _____

PATIENT DEMOGRAPHICS

Patient Name

Last Name: _____

First Name: _____ Mid Initial _____

Street Address: _____

City: _____ State: ____ Zip: _____

Telephone: (___)_____

Date of Birth___/____/____ SS#_____

☐ Single ☐ Married ☐ Employed ☐ Student

Assignment of Benefits **Release of Information**

I authorize the release of medical records necessary to process this claim. I authorize payment of medical benefits to Interscope Pathology or the staff Pathologists. I understand that I am financially responsible for all charges incurred whether or not they are paid by my insurance

_____
Signature of Insured / Responsible Person Date

INSURANCE INFORMATION

Name of Insured

Last Name: _____

First Name: _____ Mid Initial _____

Street Address: _____

City: _____ State: ____ Zip: _____

Telephone: (_____)_____

Insurance Carrier: _____

Street Address: _____

City: _____ State: ____ Zip: _____

Telephone: (_____)_____

Subscriber #_____

Medicare # _____

Clinical Information: _____

Diagnosis: _____

☐ **CORE BIOPSY**

SOURCE: 1. _____ **2.** _____ **3.** _____
4. _____ **5.** _____ **6.** _____

☐ **FINE NEEDLE ASPIRATION BIOPSY**

SOURCE: 1. _____ **2.** _____ **3.** _____
4. _____ **5.** _____ **6.** _____

☐ **TISSUE BIOPSY**

SOURCE: 1. _____ **2.** _____ **3.** _____
4. _____ **5.** _____ **6.** _____

☐ **CONSULTATION**

SOURCE: _____

White: Lab Copy Canary: Billing Pink: Client Copy