



SPOKANE (509) 892-2700/(888) 814-6277
 FAX (509) 892-2740
 BELLEVUE (425) 646-0922/(877) 288-0922
 FAX (425) 646-0925
 RICHLAND (509) 392-5920/(833) 369-7268
 FAX (509) 866-5020

LAB NUMBER

CHART #/MRN	DATE OF COLLECTION	SEX <input type="checkbox"/> M <input type="checkbox"/> F
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PATIENT'S NAME (Last Name, First Name, Middle Initial)

ADDRESS

CITY STATE ZIP PHONE

PATIENT SOCIAL SECURITY #	PATIENT BIRTHDATE
<input type="text"/>	<input type="text"/>

Please write N/A if SSN is unavailable

COPY TO:	First Name	Last Name	Location/Phone
1			
2			

INSURANCE DETAILS (Attach Front/Back Copy of MEDICAL Insurance Card)

INSURANCE NAME: POLICY/SUBSCRIBER ID #:
 CLAIMS ADDRESS: GROUP #:

- NO INSURANCE, BILL PATIENT
- CLINIC DIRECT BILL

***MEDICARE PATIENTS: SPECIMEN MUST BE SUBMITTED BY A PECOS REGISTERED PROVIDER OR PROVIDER WILL BE RESPONSIBLE FOR PAYMENT**

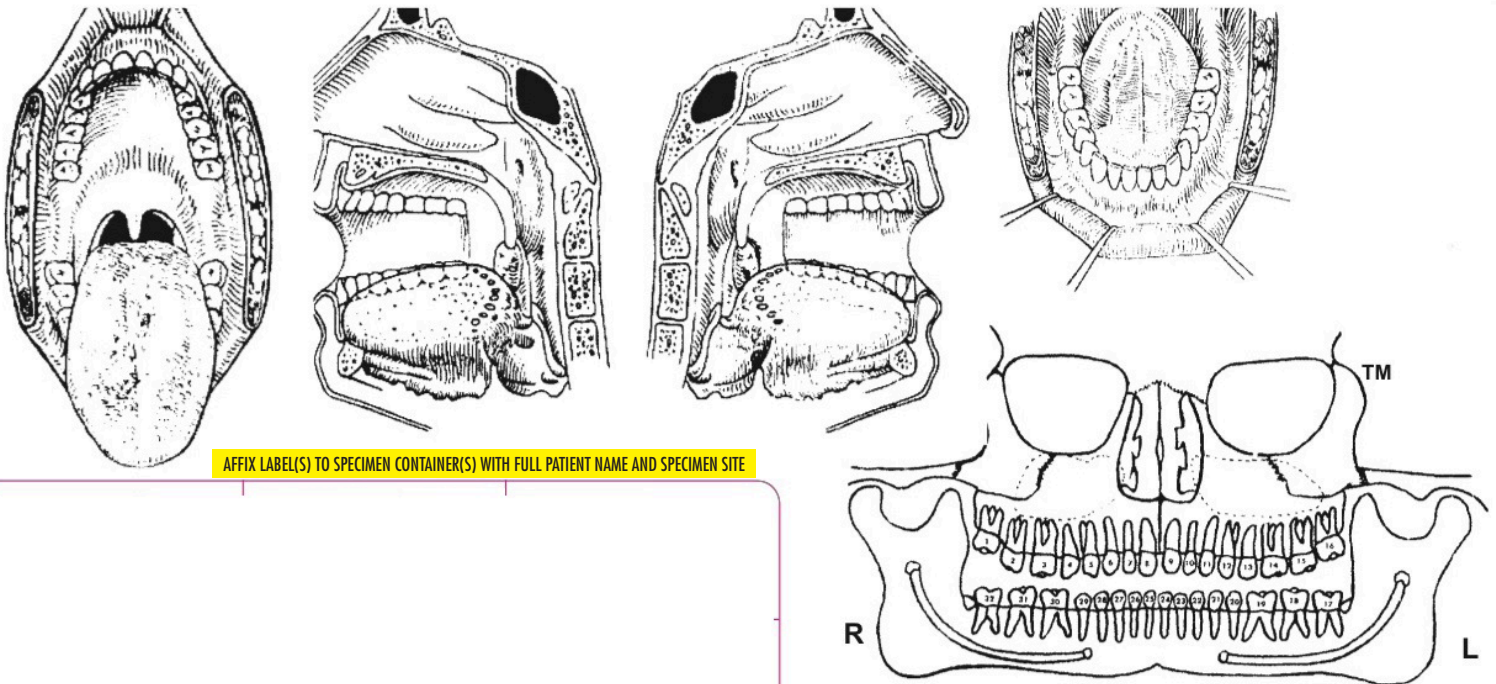
ICD-10 CODE(S) PLEASE INDICATE DIAGNOSIS CODE(S) RELATING TO THE CURRENT PROCEDURE

PREVIOUS TISSUE SENT TO OTHER LAB?
 Yes No (If yes, please attach copy of report)

Surgical Site:
 Clinical Description, Distribution, and History of Lesional Tissue (inclusion of representative radiographic imaging is additionally recommended for non-routine bone and odontogenic pathology):

L A B U S E	DATE RECEIVED
	BILLING CODES
	PREP _____

Pre/Post Operative Diagnosis:



Diagrams courtesy of Dr. Thomas G. Walsh