



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			

INSURED'S NAME (Attach Copy of **MEDICAL (NOT DENTAL)** Insurance Card)

POLICY # _____ GROUP # / EMPLOYER _____

RELATIONSHIP TO PATIENT:
 Self Spouse
 Child Other

INSURANCE PLAN NAME OR PROGRAM NAME

<input type="checkbox"/> Bill Office/ Clinic	<input type="checkbox"/> VA Choice	<input type="checkbox"/> Asuris	<input type="checkbox"/> Molina	<input type="checkbox"/> Aetna
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Group Health	<input type="checkbox"/> Premera	<input type="checkbox"/> CHPW	<input type="checkbox"/> Tricare
<input type="checkbox"/> Medicare*	<input type="checkbox"/> Regence of WA	<input type="checkbox"/> Regence of ID	<input type="checkbox"/> First Choice (Group # Req.)	
<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Regence of ID	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Medicaid (State)	
<input type="checkbox"/> Cigna (Group # Req.)	<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Medicaid (State)		
	Other _____			

*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

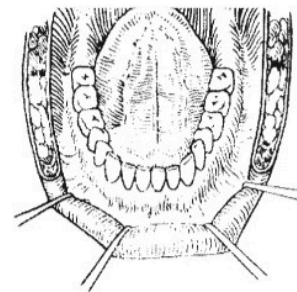
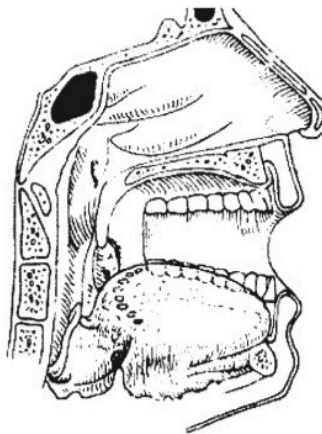
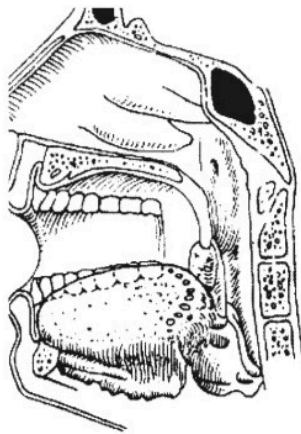
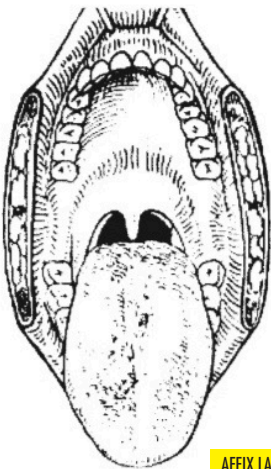
PREVIOUS TISSUE SENT TO OTHER LAB?
 Yes No (If yes, please attach copy of report)

Surgical Site:

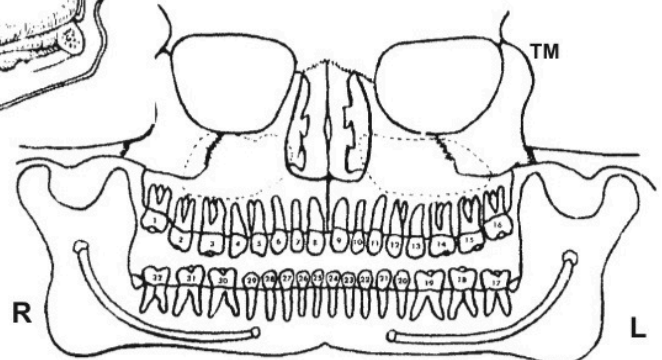
Clinical History:

Pre/Post Operative Diagnosis:

LAB USE	DATE RECEIVED
	BILLING CODES
	PREP _____



AFFIX LABEL(S) TO SPECIMEN CONTAINER(S) WITH FULL PATIENT NAME AND SPECIMEN SITE



Diagrams courtesy of Dr. Thomas G. Walsh