Patient Name: _____

DOB: _____ Age: _____ ☐ M ☐ F

SS#: _____

Address: _____

_____

office use only

Sarah Bush Lincoln
Laboratory Services
1000 Health Center Drive
P.O. Box 372
Mattoon, IL 61938
(217) 258-2247 Phone
(217)238-4584 Fax

FIN# _____

Billing:

Diagnosis & ICD-10: _____

☐ Account _____

☐ Medicare _____

☐ Medicaid _____

☐ Insurance _____

Request to bill insurance must have a copy of patient's insurance card attached.

Submitting Client: _____

Submitting Physician (printed) _____

Submitting Physician (signature) _____

Copy to Physician _____

Copy to Fax _____

Date of Procedure: _____

Brief Clinical History: (specific to procedure performed) **(required)**

Procedure Performed:

Post Operative Diagnosis:

Specimen Source/Location	Collection Time (Required)	Orientation, Comments, Requests
# _____		
# _____		
# _____		
# _____		
# _____		
# _____		

SURGICAL and CYTOLOGY REQUEST FORM

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