UNITED PATHOLOGY SERVICES
personalized service
uncompromised quality

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Patient Information		Provider Information	
Name:			
Address:			
City, State, Zip Code:		**Clinician Signature REQUIRED:**	Date
Phone Number:	Social Security Number:		
Date Of Birth:	Gender: □ Female □ Male □ Other	Copy To:	Fax:
Specimen Collection Date:		**Diagnosis/ICD-10 Codes REQUIRED:**	

Billing/Insurance (or attach copy of insurance card, front and back)					
Bill: □ Insurance □ Self-Pay □ Medicare □ Medicaid	**Insurance:**				
	Name/Relationship to Insured:				
	Company Name:			Employer Name:	
	Address:			Policy/Group #	Member ID #
	City:	State:	Zip Code:	Medicare #	Medicaid #

Cytology	Clinical History	Surgical Pathology / Histology
□ FNA site: _____ # of slides: Fixed _____ # of slides: Air Dried _____ □ Cytolyt □ Urine □ Cyst aspirate site: _____	_____ _____ _____ _____ _____ _____ _____	Tissue Submitted: List Specimen Source 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____