General Pathology

True Partners in Laboratory Diagnostics

GP 1200

Alliance Laboratories of Westchester
1 Westchester Plaza, Elmsford, NY 10523
Tel 914-307-1678 Fax 914-345-3064

PATIENT INFORMATION

Last Name	First Name		
Address		Apt #	
City	State	Zip Code	
Phone	Sex	Age	DOB
Social Security #	Medical Record #		

COLLECTION INFORMATION

Collection
Date: ____/____/____
Time: ____:____ am/pm

LAB USE ONLY

Case #: _____
Date Received: ____/____/____
Time Received: _____

BILLING INFORMATION

Name of Insured		
Company Name		
Street Address		
City	State	DOB
Policy #	Group #	
Medicare/ Medicaid #	Referral #	

ACCOUNT INFORMATION

CLINICAL INFORMATION / DIAGNOSIS

ICD-10 CODE: _____ _____

_____

HISTOLOGY

Specimen(s) Description:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

CYTOLOGY

Specimen: Urine

Test(s) required. Please check box.

- ☐ Cytology
- ☐ UroVysion
- ☐ Chlamydia/Gonorrhea
- ☐ Cytology + UroVysion
- ☐ Cytology+ Chlamydia/Gonorrhea
- ☐ Cytology+ UroVysion + CT/GC

Other: _____

_____

_____

Specimen(s) Description:

1. _____
2. _____
3. _____
4. _____

GP 1200 Pt. Name: _____ **GP 1200** Pt. Name: _____ **GP 1200** Pt. Name: _____ **GP 1200** Pt. Name: _____ **GP 1200** Pt. Name: _____ **GP 1200** Pt. Name: _____

Non-Medicare Patients: I hereby authorize Alliance Laboratories of Westchester to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Alliance Laboratories of Westchester. I understand that I am responsible for any amount not paid by insurance for reasons including, but not limited to, non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient/Responsible Party Signature: _____