immco DIAGNOSTICS
A Trinity Biotech Company

Oral Pathology
Test Request Form

PATIENT INFORMATION

Last Name

First Name

Social Security #

Sex ☐ Male ☐ Female

Race ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Other

Date of Birth (MM/DD/YYYY)

Address Apt.#

City State Zip

Telephone ( )

ATTENTION ALL PATIENTS – You are required to sign the attached Patient Consent and Financial Responsibility Form. Testing will be delayed until the completed form is received.

BILLING INFORMATION

All relevant fields below must be completed and a legible photocopy of both sides of the patient's medical insurance card(s) must accompany this form. Failure to provide all necessary information will result in direct patient billing.

Send bill to: ☐ Patient ☐ Insurance ☐ Doctor ☐ Lab

Primary Medical Insurance Name

Subscriber Name DOB

Subscriber ID #

Group #

Insurance Address

City State Zip

Insurance Phone

Secondary Medical Insurance Name

Subscriber Name DOB

Subscriber ID #

Group #

Secondary Insurance Address

City State Zip

Secondary Insurance Phone

REQUESTING PROVIDER INFORMATION

Last Name

First Name

NPI #

Address

City State Zip

Telephone ( )

Fax ( )

Are you in-network with Medicare or registered as a Medicare referring provider? ☐Yes ☐No

STUDIES REQUESTED

☐ Direct Immunofluorescence (DIF)
- ☐ Perilesional biopsy in Michel's solution
- ☐ Normal biopsy in Michel's solution

☐ Light Microscopy by H&E – lesional biopsy in 10% formalin

Physician Signature
(Required by CMS)

SPECIMEN SHIPPING

Please make sure all specimen tubes are properly labeled and place them into the clear biohazard specimen transport bag. This completed test request form, a copy of both sides of the patient's medical insurance card(s), and the signed Patient Consent and Financial Responsibility Form should be placed into the outside pocket of the specimen transport bag, which should then be put into the white cardboard mailer box. Place the white box inside of the FedEx or UPS shipping envelope/ bag that was included in your collection kit and apply the pre-paid shipping label. Contact the appropriate shipping vendor (FedEx or UPS) for pick-up for your pre-paid package.

For additional specimen collection kits please indicate the number and type you require below.

☐ #_____ DIF Collection Kits

☐ #_____ H&E Collection Kits

☐ #_____ Dual Collection Kits
(Kit includes containers for both DIF and H&E)

LIGHT MICROSCOPY (H&E)

Specimens for light microscopy are stained with H&E. Additional stains may be added to the study if required for definitive diagnosis. If more stains are added to the study there will be further charges.

SITE SELECTION: Biopsy should be taken from a lesional site, in an area without ulceration.

REQUIREMENTS: When submitting specimens for an H&E study only, one incisional or excisional biopsy specimen should be placed in the jar from the collection kit containing 10% formalin. Specimens do not need to be refrigerated or frozen.

DUAL STUDIES – DIF AND H&E

When submitting specimens for DIF and H&E studies, take one biopsy specimen from the edge of the lesion and divide it in half. Place one half in the jar from the collection kit containing 10% formalin for the H&E portion of the study and place the other half in the tube containing Michel's solution for the DIF portion of the study. A second biopsy specimen from a normal site should be placed in the tube from the collection kit containing Michel's solution. Specimens do not need to be refrigerated or frozen.

DIRECT IMMUNOFLUORESCENCE (DIF)

DIF studies include stains for IgG, IgA, IgM, Fibrin, and C3. If a connective tissue disease is suspected, C5b-9 staining will be added to the study for an additional charge. If a vesiculo-bullous disease is suspected, IgG4 staining will be added to the study for an additional charge.

SITE SELECTION

Vesiculo-Bullous Diseases: perilesional, erythematous adjacent to active or new blister

Connective Tissue Disorders: erythematous or active border of new lesion

Lichen Planus and Lichnoid Reactions: new lesion

REQUIREMENTS: When submitting specimens for a DIF study only, one biopsy specimen from the edge of the lesion should be placed in the red tube from the collection kit containing Michel's solution. A second biopsy specimen from a normal site should be placed in the purple tube from the collection kit containing Michel's solution. Specimens do not need to be refrigerated or frozen.

SPECIMEN INFORMATION

Please complete relevant fields in the sections below. Failure to provide all necessary information will delay the diagnostics report.

Specimen Date (required)

Biopsy Site Description ☐ Excisional ☐ Incisional ☐ Other _____

Surgical Findings

CLINICAL INFORMATION

ICD-10 Code (required)	Suspected Diagnosis

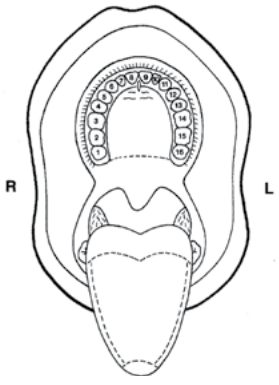
Summary of Current Problem (reason for biopsy)
(symptoms, duration, previous related treatment, etc.)

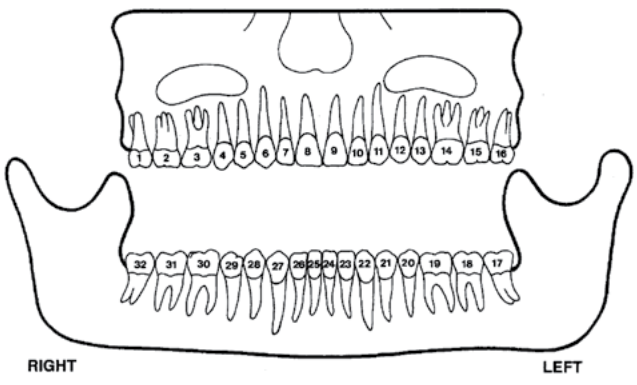
Medical/Dental History
(pertinent diseases, drugs & medications, oral habits, family history, etc.)

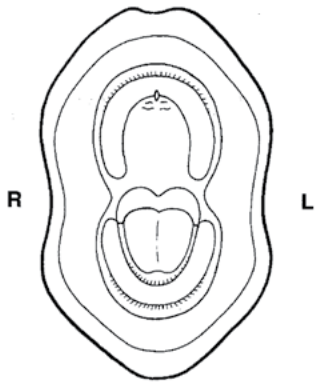
Clinical Findings
(size, shape, color, consistency, etc.)

Radiographic Findings
(size, shape, borders, definition, radiolucent vs radiopaque, relation to teeth, etc.)

Prior Study Results







Immco Diagnostics, Inc.
10 Earhart Drive
Suite 100
Williamsville, NY 14221

+1.716.691.0091
1.800.537.TEST
+1.716.691.6955 Fax
laboratoryservices@immco.com

www.immco.com

ML 48 REV 8/18

DO NOT DETACH

Immco Diagnostics, Inc.
10 Earhart Drive
Suite 100
Williamsville, NY 14221
Phone: 1.800.537.TEST
Fax: 716.691.6955
E-Mail: laboratoryservices@immco.com

ALL PATIENTS ARE REQUIRED TO READ, SIGN AND DATE THIS PATIENT CONSENT AND FINANCIAL RESPONSIBILITY FORM. THE COMPLETED FORM MUST ACCOMPANY THE SPECIMEN BEING SENT TO IMMCO DIAGNOSTICS, INC. TESTING WILL BE DELAYED UNTIL THE COMPLETED CONSENT FORM IS RECEIVED.

PATIENT CONSENT AND FINANCIAL RESPONSIBILITY FORM

PATIENT NAME: _____
(printed)

LEGAL GUARDIAN OR POWER OF ATTORNEY: _____
(*if applicable) (printed)

As a result of thorough evaluation by your doctor, a biopsy specimen is being sent to Immco Diagnostics, Inc. for analysis and diagnosis by our board-certified Oral and Maxillofacial Pathologists. A written report of the results will be sent to your doctor and they will discuss the results with you. The testing being ordered by your doctor is considered a medical procedure and Immco Diagnostics, Inc. will bill your medical insurance.

As a courtesy to you, Immco Diagnostics, Inc. will bill your medical insurance if we are provided with a completed test request form and a legible copy of both sides of your insurance card(s). If we do not receive all of the required insurance information you will receive a bill directly from Immco Diagnostics, Inc. Please be aware that we may not be in-network with your carrier and that insurance payments can vary depending on your coverage. Ultimately you are responsible for the full payment of the bill and you are responsible for any fees or balances that are not covered by your insurance. In rare cases, it may be necessary to send your processed biopsy to an external consultant for an expert second opinion. This second opinion will result in further charges that will be billed to you or your medical insurance by the external consultant.

I certify that I have read and understand the information above and consent to the testing procedure(s). I understand that my biopsy specimen(s) is being sent to Immco Diagnostics, Inc. for analysis and I accept full financial responsibility for any fees charged for these services that are not covered by my medical insurance. I also understand that if my biopsy is sent to an external consultant for a second opinion I will be financially responsible for those fees as well. I agree to pay for all related charges within 30 days of the receipt of the bill and if my account is transferred to any outside entity for collections due to delinquent payment, I agree to pay for the collections agency fee of up to 30% of the total charges, reasonable attorney fees and court costs in connection with obtaining full payment.

I authorize Immco Diagnostics, Inc. to release medical reports and other information to health insurance or similar companies as necessary to process insurance claims and I authorize my insurance carrier to pay benefits directly to Immco Diagnostics, Inc. I also authorize the release of my information to any collections agency to which my account may be assigned to for collections. I also give my permission to Immco Diagnostics, Inc. to share my protected health information with other licensed healthcare providers as needed and requested for diagnostic and/or treatment purposes within HIPAA regulations.

_____
Signature of Patient, Legal Guardian, or Power of Attorney Date