

SUBMITTING CLINICIAN: PLEASE TEAR OFF THIS SHEET & GIVE IT TO YOUR PATIENT

FOR THE PATIENT: IMPORTANT INFORMATION ABOUT LABORATORY BILLING

As part of your care, your doctor is sending your biopsy specimen to the UCSF Oral Pathology Diagnostic Laboratory for microscopic examination, diagnosis and reporting. The fee for our laboratory service is not included in your doctor's charge and you will receive a separate statement from us for this service. Our policy concerning billing is listed below. Please read this information carefully.

BILLING POLICY	WHY YOU MAY RECEIVE AN INVOICE	DUE UPON RECEIPT
<ul style="list-style-type: none">• We will bill your medical or dental insurance for this procedure on your behalf• Our laboratory services are considered a medical benefit and are usually covered by your medical insurance, Medicare or Medi-Cal. Please check with your plan if you are uncertain of coverage provisions• Make sure that your clinician provides to us all your insurance information including a copy of your benefit card and your correct contact information• You will receive a mailed statement from us each month until the account is settled• Co-insurance, co-payment or deductibles are determined by your insurance plan and are your responsibility to pay.	<ul style="list-style-type: none">• Insufficient or no insurance information has been provided to us• Incorrect contact information or address. Please make sure that your personal information is correctly supplied• No response from your insurance company. If this happens then it is your responsibility to resolve the matter• Any disputes with your insurance company involving participating providers, coverage, eligibility or unpaid balances are your responsibility to resolve	<ul style="list-style-type: none">• All charges are payable once you receive an invoice for our services• If you are unable to pay the account then please contact us as soon as possible <p>FOR ALL ACCOUNT & BILLING QUESTIONS:</p> <p>UCSF Oral Pathology Billing Office P.O. Box 10076 Van Nuys, CA 91410-0076 Tel: (888) 582-3397 ext 300</p>



University of California
San Francisco

TISSUE EXAMINATION REQUEST FORM

UCSF Oral Pathology Diagnostic Laboratory
513 Parnassus Avenue, Room S-512
San Francisco, CA 94143-0424
Tel: (415) 476-4866 Fax: (415) 476-6482

Lab use only:	<input type="checkbox"/> Mail	<input type="checkbox"/> Courier
Date rec'd:	_____	

SUBMITTING CLINICIAN INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____

PATIENT INFORMATION:

Name: _____ SSN: _____ - _____ - _____ *

Male Female Date of Birth: (mm/dd/yyyy) _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Home Tel #: (____) _____ - _____ Work Tel #: (____) _____ - _____

* PRIVACY ACT STATEMENT: We require the Social Security Number on this form to ensure compliance with the insurance company's claim filing procedures

BILLING INFORMATION: (Please check one)

Bill patient directly Medical Insurance Dental Insurance

MEDICARE MEDI-CAL

INSURANCE INFORMATION:

Insured Name: _____ Date of birth: _____

Subscriber #: _____ Group #: _____

Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

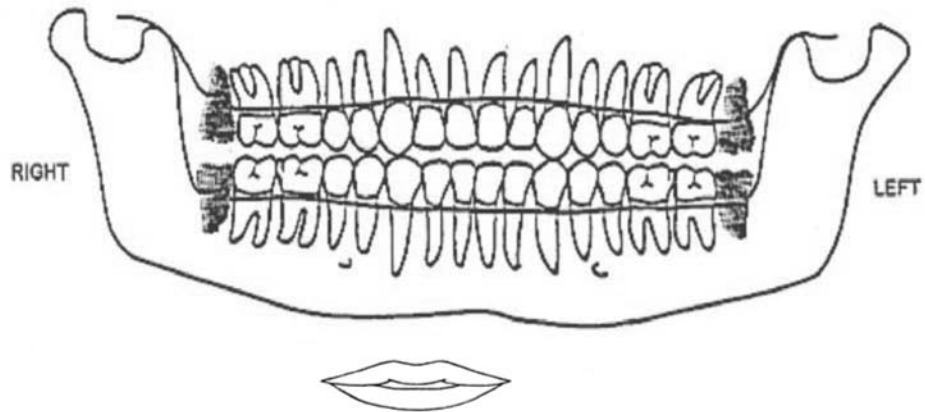
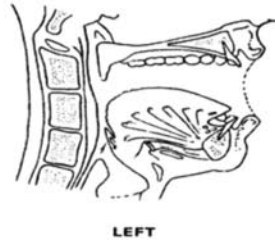
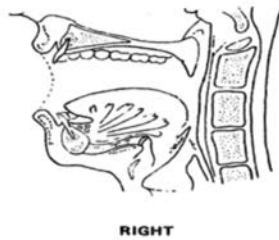
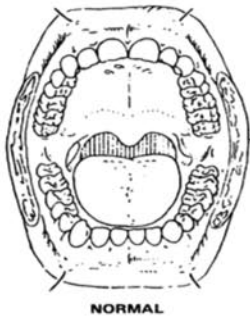
CLINICAL INFORMATION:

Date of biopsy procedure: (mm/dd/yyyy) _____-_____-_____ Biopsy type: Incisional Excisional

Patient Age: _____ (years) Gender: Female Male

Location (or identify below): _____

History and description:



CLINICAL IMPRESSION: _____

Radiographs/photos submitted? NO YES

Previous biopsy: NO YES

UCSF #: OP _____-_____

Please send _____ more biopsy kits

For lab use only: