Case Number

LAB10

ALLINA HEALTH LABORATORY
HISTOPATHOLOGY REQUEST
2800 10th Ave. S., Ste 2000, Minneapolis, MN 55407
Phone: 612-863-4678 • Fax: 612-863-4067
HOSPITAL PATHOLOGY ASSOCIATES, P.A.

BILL TO (MUST CHECK ONE): ☐ CLIENT ☐ PATIENT/INSURANCE

Submitter: XADO (Opt OUT/Non-Participating Patient)

Facility Name: _____

Phone: (_____)_____ - _____

Provider Name: _____

Provider Allina Health ID Number: _____
-OR-
Provider NPI Number: _____

Fax report to: (_____)_____ - _____

*Include COMPLETE Insurance Information and diagnosis

***Additional* copy of pathology report should be sent to:**

Provider : _____
First Name MI Last Name

Practice name:_____

Fax #:_____

Reports cannot be faxed if complete information is not provided

DATE & TIME COLLECTED

GENDER: ☐ MALE ☐ FEMALE

BIRTH DATE (MM-DD-YYYY) - -

PATIENT NAME: LAST, FIRST M.I.

CHART #

PATIENT ADDRESS : STREET and CITY

STATE ZIP

PATIENT PHONE ( )

☐ MEDICARE PRIMARY ☐ MEDICARE SECONDARY

MEDICARE

MEDICAL ASSISTANCE NUMBER

STATE

INSURANCE CO. NAME

RELATIONSHIP OF PATIENT TO INSURED
☐ SELF ☐ SPOUSE ☐ DEPEND. ☐ OTHER

POLICY HOLDER'S NAME

POLICY HOLDER DATE OF BIRTH (IF NOT PATIENT) - -

SUBSCRIBER ID #

GROUP #

INSURANCE

Pathology Testing will always be ordered/performed on appropriate specimens for all samples submitted with this requisition.

PROVIDER SIGNATURE**:**

6292 and 12482

Specimen	Source (specific)	Date excised	Time excised	Date in formalin	Time in formalin
A					
B					
C					
D					
E					
F					
G					
H					
I					

Clinical information **(reason for biopsy)** and previous tissue or cytology diagnosis:

Affix RQ Label Here

HISTO (7/17) Number of Containers _____ ☐ Ordered by (A#) _____