SPOKANE
(509) 892-2700/(888) 814-6277
FAX (509) 892-2740
BELLEVUE
(425) 646-0922/(888) 814-6277
FAX (425) 646-0925

LAB NUMBER

CHART #/MRN | **DATE OF COLLECTION** | **SEX** ☐ M ☐ F

PATIENT'S NAME (Last Name, First Name, Middle Initial)

ADDRESS

CITY **STATE** **ZIP** **PHONE**

PATIENT SOCIAL SECURITY #

Please write N/A if SSN is unavailable

PATIENT BIRTHDATE

COPY TO: First Name Last Name Location/Phone
1
2

INSURED'S NAME (Attach Copy of MEDICAL (NOT DENTAL) Insurance Card)

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Child ☐ Other

POLICY # GROUP # / EMPLOYER

INSURANCE PLAN NAME OR PROGRAM NAME

☐ Bill Office/ Clinic ☐ VA Choice
☐ No Insurance ☐ Group Health ☐ Asuris ☐ Molina ☐ Aetna
☐ Medicare* ☐ Regence of WA ☐ Premera ☐ CHPW ☐ Tricare
☐ United Healthcare ☐ Regence of ID ☐ First Choice (Group # Req.) _____
☐ Cigna (Group # Req.) ☐ Blue Cross ☐ Medicaid (State) _____
Other _____

***MEDICARE PATIENTS**: SPECIMEN MUST BE SUBMITTED BY A **PECOS** REGISTERED PROVIDER OR PROVIDER WILL BE RESPONSIBLE FOR PAYMENT

ICD-10 CODE(S) PLEASE INDICATE DIAGNOSIS CODE(S) RELATING TO THE CURRENT PROCEDURE

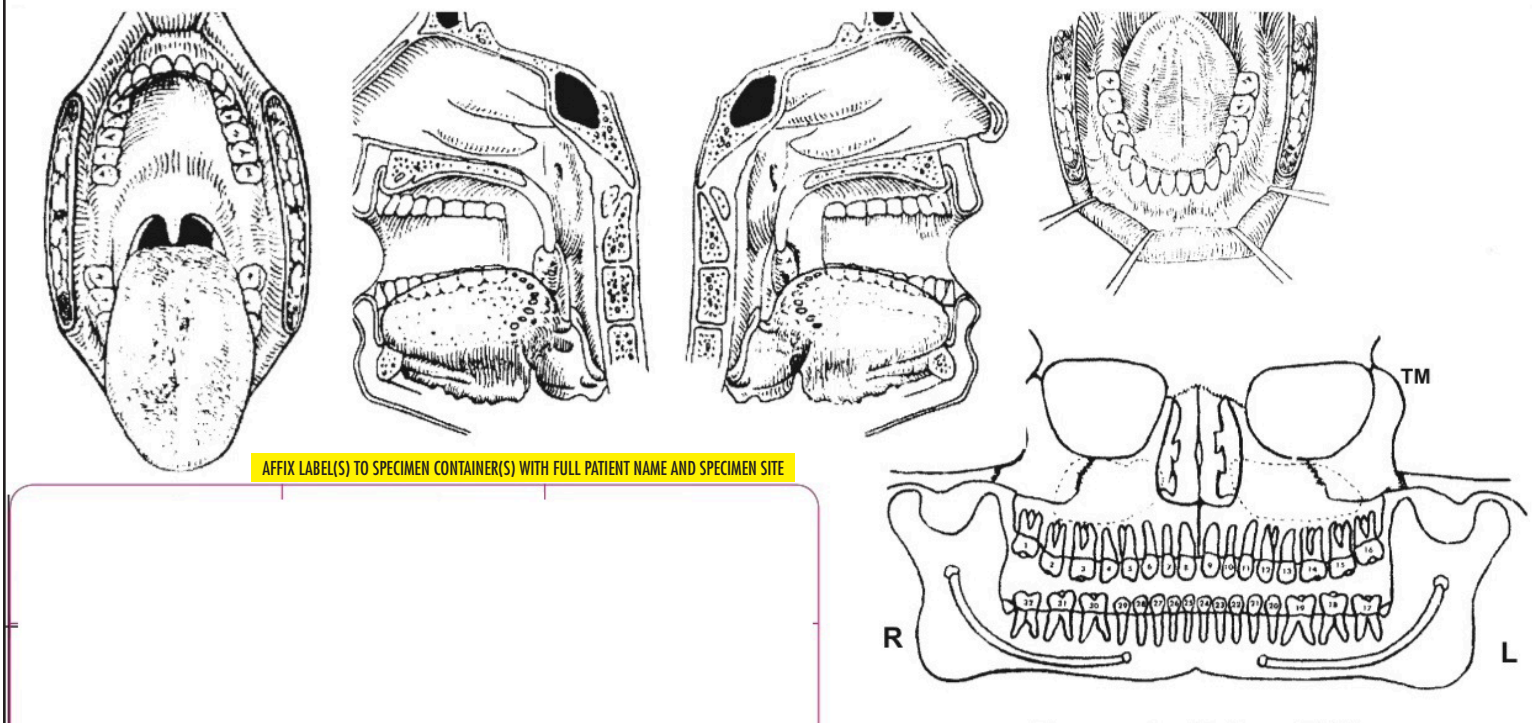
PREVIOUS TISSUE SENT TO OTHER LAB?
☐ Yes ☐ No (If yes, please attach copy of report)

Surgical Site:

Clinical History:

Pre/Post Operative Diagnosis:

LAB USE
DATE RECEIVED
BILLING CODES
PREP



Diagrams courtesy of Dr. Thomas G. Walsh

AFFIX LABEL(S) TO SPECIMEN CONTAINER(S) WITH FULL PATIENT NAME AND SPECIMEN SITE