bako dx

855-422-5628 Fax: 770-475-0528

Bako Diagnostics
6240 Shiloh Rd
Alpharetta, GA 30005

Date collected: _____ /_____ /_____

Time collected: _____

Version 8.26.21

PHYSICIAN / CLINIC INFORMATION

LAB USE ONLY

BD2100000

DERMATOLOGY REQUISITION

######

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ Apt/Suite:_____ City:_____ State:__ __ Zip Code:_____

Date of Birth:__ __ / __ __ / __ __ __ __ Sex:_____ Patient ID:_____ Phone #:__ __ __ - __ __ __ - __ __ __ __

BILLING INFORMATION *(Attach a copy of primary/secondary insurance cards– both sides)*

Bill:
☐ Insurance
☐ Patient

Primary Medical Insurance

Insured Name: _____ Insurance Provider:_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent Member ID:_____

Group #:_____

CLINICAL INFORMATION

Specimen		Skin	Nail
A **Name:**_____ **Site:**_____ ☐ Clinical image submitted to: https://images.bakodx.com	**A** ☐ Margins: _____ ☐ Excision ☐ Shave ☐ Punch ☐ Other	☐ Pigmented Lesion (Rule out Melanoma) ☐ Non-Pigmented Lesion (Verruca/Rule out Carcinoma) ☐ Dermatitis (Eczematous/Tinea) ☐ Ulceration (Malignancy/Vasculitis) ☐ Other: _____	☐ **COMPREHENSIVE NAIL ANALYSIS** Higher Sensitivity & Melanin Screen (PAS / GMS / FM) **NAIL UNIT DYSTROPHY (Fungal, Inflammatory, Neoplasm)** ☐ Higher Sensitivity & Melanin Screen (PAS / GMS / FM) (Dematiaceous fungi / Melanoma) ☐ Higher Sensitivity (PAS / GMS) ☐ Routine (PAS) **FUNGAL SPECIATION / ORGANISM IDENTIFICATION** (Typically added to above stain(s), submitted dry) ☐ PCR with Terbinafine resistance reflex* OR ☐ Culture ☐ PCR w/o Terbinafine resistance reflex **NEOPLASIA** ☐ Pigmented Streak / Lesion (R/O Melanoma) ☐ Non-Pigmented / Lesion (Verruca / R/O Carcinoma) *Not available in NY.
Additional Clinical Information:			**ICD 10** (Required for PCR testing)
B **Name:**_____ **Site:**_____ ☐ Clinical image submitted to: https://images.bakodx.com	**B** ☐ Margins: _____ ☐ Excision ☐ Shave ☐ Punch ☐ Other	☐ Pigmented Lesion (Rule out Melanoma) ☐ Non-Pigmented Lesion (Verruca/Rule out Carcinoma) ☐ Dermatitis (Eczematous/Tinea) ☐ Ulceration (Malignancy/Vasculitis) ☐ Other: _____	☐ **COMPREHENSIVE NAIL ANALYSIS** Higher Sensitivity & Melanin Screen (PAS / GMS / FM) **NAIL UNIT DYSTROPHY (Fungal, Inflammatory, Neoplasm)** ☐ Higher Sensitivity & Melanin Screen (PAS / GMS / FM) (Dematiaceous fungi / Melanoma) ☐ Higher Sensitivity (PAS / GMS) ☐ Routine (PAS) **FUNGAL SPECIATION / ORGANISM IDENTIFICATION** (Typically added to above stain(s), submitted dry) ☐ PCR with Terbinafine resistance reflex* OR ☐ Culture ☐ PCR w/o Terbinafine resistance reflex **NEOPLASIA** ☐ Pigmented Streak / Lesion (R/O Melanoma) ☐ Non-Pigmented / Lesion (Verruca / R/O Carcinoma) *Not available in NY.
Additional Clinical Information:			**ICD 10** (Required for PCR testing)
C **Name:**_____ **Site:**_____ ☐ Clinical image submitted to: https://images.bakodx.com	**C** ☐ Margins: _____ ☐ Excision ☐ Shave ☐ Punch ☐ Other	☐ Pigmented Lesion (Rule out Melanoma) ☐ Non-Pigmented Lesion (Verruca/Rule out Carcinoma) ☐ Dermatitis (Eczematous/Tinea) ☐ Ulceration (Malignancy/Vasculitis) ☐ Other: _____	☐ **COMPREHENSIVE NAIL ANALYSIS** Higher Sensitivity & Melanin Screen (PAS / GMS / FM) **NAIL UNIT DYSTROPHY (Fungal, Inflammatory, Neoplasm)** ☐ Higher Sensitivity & Melanin Screen (PAS / GMS / FM) (Dematiaceous fungi / Melanoma) ☐ Higher Sensitivity (PAS / GMS) ☐ Routine (PAS) **FUNGAL SPECIATION / ORGANISM IDENTIFICATION** (Typically added to above stain(s), submitted dry) ☐ PCR with Terbinafine resistance reflex* OR ☐ Culture ☐ PCR w/o Terbinafine resistance reflex **NEOPLASIA** ☐ Pigmented Streak / Lesion (R/O Melanoma) ☐ Non-Pigmented / Lesion (Verruca / R/O Carcinoma) *Not available in NY.
Additional Clinical Information:			**ICD 10** (Required for PCR testing)

PHYSICIAN NOTICE: *When ordering tests, the physician is required to make an independent medical necessity decision with regard to each test the laboratory will bill. The physician also understands he or she is required to (1) submit ICD-10 diagnosis supported in the patient's medical record as documentation of the medical necessity or (2) explain and have the patient sign an ABN.*

PHYSICIAN SIGNATURE

The requested test(s) is/are medically indicated for patient management.

SIGNATURE REQUIRED_____

PATIENT SIGNATURE

I authorize Bako Diagnostics to bill my insurance.

SIGNATURE_____ DATE____/____/_____