

DATE COLLECTED ____/____/____ TIME COLLECTED: _____

BILL: INSURANCE PATIENT

PATIENT INFORMATION

LAST NAME		FIRST NAME	M.I.
STREET ADDRESS			APT. #
CITY	STATE	ZIP CODE	
PHONE NUMBER			
DATE OF BIRTH	AGE	SEX	PATIENT ID

PRIMARY INSURANCE (ATTACH A COPY OF INSURANCE CARD – BOTH SIDES)

SUBSCRIBER NAME/RELATIONSHIP TO SUBSCRIBER: Self Spouse Dependent

INSURANCE NAME

ADDRESS

CITY STATE ZIP CODE

EMPLOYER NAME

SUBSCRIBER DOB: / / GROUP/CONTRACT # MEMBER ID #

SUBSCRIBER SEX: Male Female MEDICARE ID # MEDICAID ID #

SECONDARY INSURANCE (ATTACH A COPY OF INSURANCE CARD – BOTH SIDES)

SUBSCRIBER NAME/RELATIONSHIP TO SUBSCRIBER: Self Spouse Dependent

INSURANCE NAME

ADDRESS

CITY STATE ZIP CODE

EMPLOYER NAME

SUBSCRIBER DOB: / / GROUP/CONTRACT # MEMBER ID #

SUBSCRIBER SEX: Male Female MEDICARE ID # MEDICAID ID #

SPECIMEN SITE	MARG	SURGICAL PATHOLOGY PRE/POST-OP DIAGNOSIS	
1. Name: _____	<input type="checkbox"/>	_____	<input type="checkbox"/> BX <input type="checkbox"/> P.BX <input type="checkbox"/> EX <input type="checkbox"/> SH.EX
2. Name: _____	<input type="checkbox"/>	_____	<input type="checkbox"/> BX <input type="checkbox"/> P.BX <input type="checkbox"/> EX <input type="checkbox"/> SH.EX
3. Name: _____	<input type="checkbox"/>	_____	<input type="checkbox"/> BX <input type="checkbox"/> P.BX <input type="checkbox"/> EX <input type="checkbox"/> SH.EX
4. Name: _____	<input type="checkbox"/>	_____	<input type="checkbox"/> BX <input type="checkbox"/> P.BX <input type="checkbox"/> EX <input type="checkbox"/> SH.EX

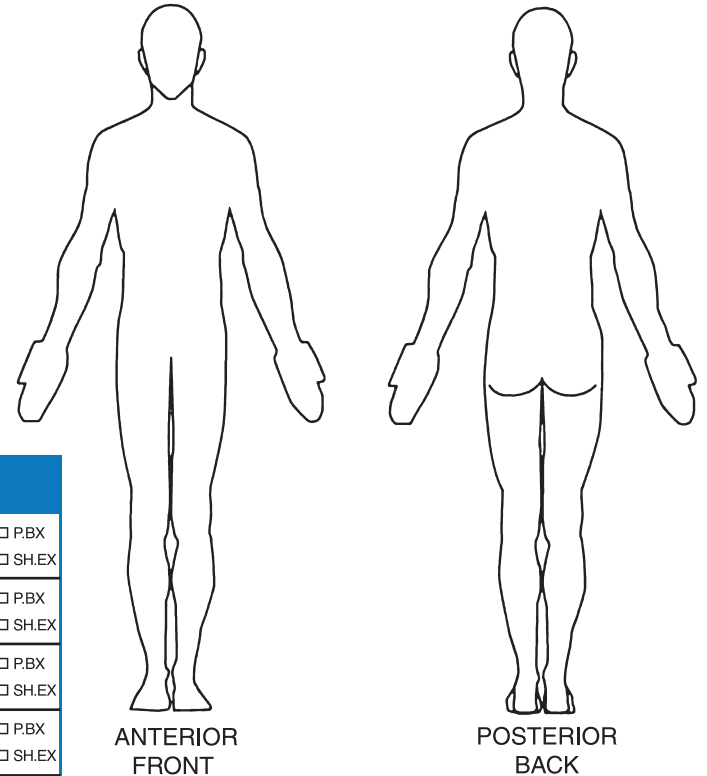
PHYSICIAN/CLINIC INFORMATION



196124

**LAB
USE
ONLY**

PLEASE INDICATE SITE WITH CORRESPONDING SPECIMEN NUMBER



ADDITIONAL CLINICAL INFORMATION / DIAGNOSIS CODES (IF A CLINICAL IMAGE IS AVAILABLE PLEASE PRINT AND ATTACH)

PHYSICIAN SIGNATURE

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

I authorize Bako Diagnostics to bill my insurance.

SIGNATURE REQUIRED

SIGNATURE _____ DATE ____/____/____

SPECIMEN CONTAINER MUST INCLUDE PATIENT NAME, SITE AND BARCODED LABEL

Specimen Site 1



196124

Specimen Site 2



196124

Specimen Site 3



196124

Specimen Site 4



196124

Name _____

Name _____

Name _____

Name _____