

Practice Name : _____

Collection Date: _____ Collection Time: _____

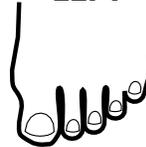
PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth: _____ Gender: Male Female MRN/PUI: _____
 Social Security: _____ Commercial Medicaid Worker's Comp Self Pay Other
 Insurance Co: _____ Insurance ID#: _____
Ensure that a photocopy is provided of the front and back of insurance card

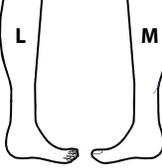
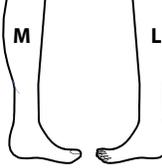
CLINICAL INFORMATION

SPECIMEN #1		SPECIMEN #2	
<input type="radio"/> Right <input type="radio"/> Left	<input type="radio"/> Shave <input type="radio"/> Punch <input type="radio"/> Excision Other: _____	<input type="radio"/> Right <input type="radio"/> Left	<input type="radio"/> Shave <input type="radio"/> Punch <input type="radio"/> Excision Other: _____

NAIL

NAIL UNIT DYSTROPHY		PLEASE INDICATE PRECISE SITE OF ORIGIN (1,2)		NAIL UNIT DYSTROPHY	
<input type="radio"/> Fungal	<input type="radio"/> Inflammatory	<input type="radio"/> Neoplasm	RIGHT	LEFT	<input type="radio"/> Fungal
NEOPLASIA	<input type="radio"/> Pigmented Streak/Lesion (R/O Melanoma)	<input type="radio"/> Non-Pigmented Lesion (Verruca / R/O Carcinoma)			<input type="radio"/> Inflammatory
<input type="radio"/> Pigmented Streak/Lesion (R/O Melanoma)	<input type="radio"/> Non-Pigmented Lesion (Verruca / R/O Carcinoma)				<input type="radio"/> Neoplasm
					NEOPLASIA
					<input type="radio"/> Pigmented Streak/Lesion (R/O Melanoma)
					<input type="radio"/> Non-Pigmented Lesion (Verruca / R/O Carcinoma)

SKIN/SOFT TISSUE

MARGINS <input type="radio"/> Yes <input type="radio"/> No		RIGHT LEFT		MARGINS <input type="radio"/> Yes <input type="radio"/> No	
SKIN	<input type="radio"/> Pigmented Lesion (R/O Melanoma)	L	M	M	SKIN
<input type="radio"/> Non-Pigmented Lesions (Verruca / R/O Carcinoma)	<input type="radio"/> Dermatitis (Eczematous/Tinea)				<input type="radio"/> Pigmented Lesion (R/O Melanoma)
<input type="radio"/> Ulceration (Malignancy/Vasculitis)	<input type="radio"/> Other: _____				<input type="radio"/> Non-Pigmented Lesions (Verruca / R/O Carcinoma)
SOFT TISSUE	<input type="radio"/> Tumor (Ganglion/Lipoma/Sarcoma)				<input type="radio"/> Dermatitis (Eczematous/Tinea)
<input type="radio"/> Inflammatory (Tophus/Abscess)					<input type="radio"/> Ulceration (Malignancy/Vasculitis)
					<input type="radio"/> Other: _____
					SOFT TISSUE
					<input type="radio"/> Tumor (Ganglion/Lipoma/Sarcoma)
					<input type="radio"/> Inflammatory (Tophus/Abscess)

MEDICAL NECESSITY - MUST BE COMPLETED

Signs and Symptoms for Testing (ICD-10 Codes):

Notice to Ordering Provider: A provider must order only those tests that are medically necessary for the patient, given his or her clinical condition. Provider must submit the diagnosis information for all tests ordered and medical necessity should be documented in the patient's medical record. Medicare, Medicaid, and/or other third party payers will only pay for tests that meet the payer's coverage criteria and are reasonable and necessary to treat or diagnose the patient.

Provider Signature Attestation: I understand that if I order medically unnecessary tests that are billed to Medicare, Medicaid, and/or other third party payers, I may be subject to sanctions or remedies under civil, criminal or administrative law. I also attest that the documentation of the medical necessity of all tests ordered has been documented in the patient's medical record. **Note:** Medicare generally does not cover routine screening tests.

Ordering Provider: _____ NPI: _____

Provider Signature: _____ Date: _____