Request for Laboratory Study

LABORATORY USE ONLY

ORAL & MAXILLOFACIAL PATHOLOGY SERVICE – SCHOOL OF DENTISTRY
Box 357133 Seattle, WA 98195-7133 PH: 206-543-4440 FAX: 206-543-8054
EMAIL: **omps@uw.edu** **dental.washington.edu/oralpath**

***Please consult our referral email policy.**

Please include copies of the front and back of medical and dental insurance cards.
State law requires patient's name and date of birth on biopsy bottles.

Please select one of the following
- ☐ No Insurance
- ☐ Medical & Dental Attached
- ☐ Please Bill Doctor

→ **Date of Biopsy** (MM / DD / YYYY) _____

PATIENT INFORMATION – ALL SECTIONS BELOW ARE MANDATORY – PLEASE TYPE OR PRINT CLEARLY

Patient's Name (Last)	(First)	(Middle)	**DOB of Patient**	Sex ☐ Male ☐ Female	Ethnicity
If Minor, Parent or Guardian Name (Last)	(First)	(Middle)	**DOB of Parent/Guardian**	Social Security No.*	
Patient's Address (Number & Street) (Apt. #)					Home Phone
(City) (State) (ZIP)					Mobile Phone

PERFORMING DOCTOR INFORMATION

Doctor's Name (Last) (First) (M.I.)	Email and or Website	NPI No.
Doctor's Address (Number & Street)	(Suite #)	Phone
(City)	(State) (ZIP)	Fax No.

MEDICAL INFORMATION – Description of Lesion

Location

Size

Color

Symptoms

Associated Findings and Past History

Previous Biopsy Case No.

Smoking and Alcohol Use (optional)

Has the patient ever used tobacco products? ☐ Yes ☐ No

Number of years _____

Current use? ☐ Yes ☐ No

What type? ☐ Cigarette ☐ Pipe/Cigar ☐ Smokeless ☐ Beer ☐ Wine ☐ Other _____

Mouthwash (brand) _____

Toothpaste (brand) _____

PROCEDURE AND RESULTS

Radiographic Findings

Clinical Impression

Images (photographs/radiographs)
- ☐ Find Enclosed
- ☐ Images emailed to omps@uw.edu (*JPEGs are preferred*)
- ☐ Sent in separate envelope

Type of Biopsy ☐ Incisional ☐ Excisional ☐ Curettage ☐ Laser ☐ Other (specify) _____

* The Oral and Maxillofacial Pathology Service has requested your Social Security Number because it serves as a unique identifier. Disclosure of the number is voluntary and no statute or rule specifically directs the Service to request the number. If you decline to provide the number, the Service shall not for that reason deny diagnostic services.

Form Completed by _____

Performing Doctor's Signature **Doctor's Printed Name** Date

RESET FORM

SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Attention Dental Staff:

Please give this letter to your patient and have them sign it at the bottom

Your dentist has requested our help in making a diagnosis for you. The tissue removed by your dentist will be mailed to our laboratory at the University of Washington. Your tissue specimen will be processed in thin sections, placed on microscopic slides and stain in ways to help determine a definitive diagnosis. The stained slides are evaluated microscopically by Dr. Hiba Qari, Oral Pathologist. We are delighted to be of service to you and the provider that submitted the tissue specimen to our laboratory. A formal report will be generated and forwarded to your dentist/oral surgeon to guide your treatment. Like the services of any other medical consultant, our oral pathology biopsy services (OPBS) are billed separately from the services of your dentist.

To clarify: The processing of your biopsy by the OPBS means the following:

1. You will be billed for the technical processing and professional reading of your biopsy specimen as one bill.
2. The OPBS lab charges are separate from that of your dentist who performed the biopsy.

In order to process the billing for your tissue specimen, we will need you to forward your **medical insurance information** to us through your dentist office. We will use this information to bill your medical insurance based upon the site of the biopsy and the final diagnosis of your specimen.

If you any have questions or concern about the pathology service contact us at 206-543-4440. For any matter related to billing, please call our billing office at 206-543-5297
We appreciate the opportunity to assist in your oral health care.

I have read the letter and understand UW School of Dentistry's process of diagnosis and billing:

Name: _____ Signature: _____ Date: _____

*Please consult our referral email policy.

WHY YOU MAY RECEIVE A BILL

- **Insufficient insurance information or no insurance provided.**
- **No response from your insurance company.** When this happens, it is your responsibility to resolve this matter with your insurance company.
- **Co-insurance, co-payment, or deductible.** This is the amount due from you as determined by your insurance plan. Please contact your insurance for your plan benefits.

Any disputes with your insurance company involving participating providers, coverage, eligibility or unpaid balance will be your responsibility.

BILLING POLICY

Please attach a copy of the front & back of your insurance cards so we can process your insurance coverage accordingly.

Our laboratory services are usually considered a medical benefit. Subsequently, we can bill your medical insurance.

If your medical insurance requires a referral for laboratory services, please contact your primary care physician.

Statements will be mailed to you every month to show all activities on your account, until your balance is paid in full.

DUE UPON RECEIPT

All charges are due and payable upon receipt of statement. Your account is past due if not paid by the end of the month, unless your insurance is being actively billed. If you are unable to pay the entire balance, please contact our office immediately to discuss payment arrangements.

A fee of $25.00 will be assessed for any returned checks.

	Medical Insurance	
PRIMARY	Subscriber's Name	Patient's Relationship to Subscriber
	Medical Insurance NAME, Claim filing ADDRESS and PHONE or write "N/A" if NONE	
	Insurance ID number* **(Mandatory)**	
	Subscriber's Birth Date (if not patient)	Insurance Group No.
	Medical Insurance	
SECONDARY	Subscriber's Name	Patient's Relationship to Subscriber
	Medical Insurance NAME, Claim filing ADDRESS and PHONE or write "N/A" if NONE	
	Insurance ID number* **(Mandatory)**	
	Subscriber's Birth Date (if not patient)	Insurance Group No.

ASSIGNMENT OF BENEFITS

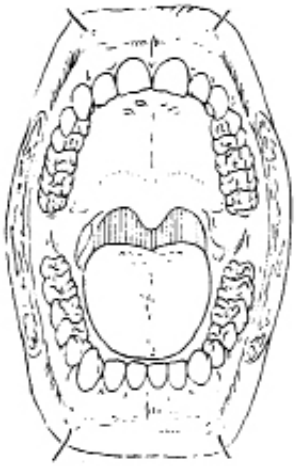
I understand the billing policy and I authorize the release of any medical, dental, or other information to process this claim. I also authorize payment of government benefits and my insurances to make any payments directly to the University of Washington, Oral & Maxillofacial Pathology Service, for laboratory services provided.

_____ _____

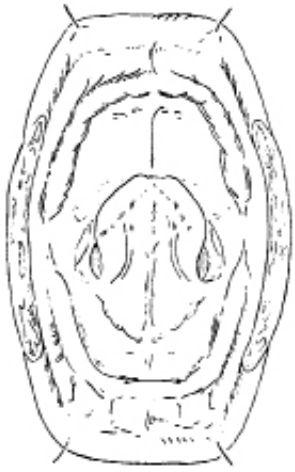
Signature of insured or authorized person REQUIRED **Date**

* PRIVACY ACT STATEMENT: We require your Social Security Number on this form to ensure compliance with your insurance company's claim filing procedures. If your insurance uses a different number as your identification number we do not require you to disclose your Social Security Number.

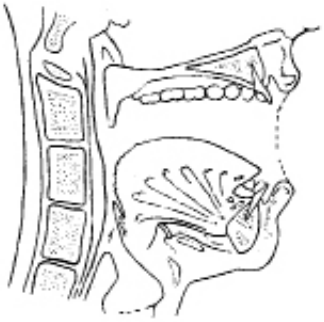
***Please consult our referral email policy.**



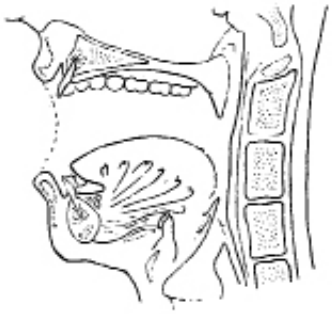
NORMAL



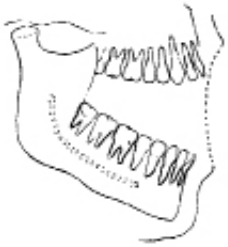
EDENTULOUS



RIGHT



LEFT



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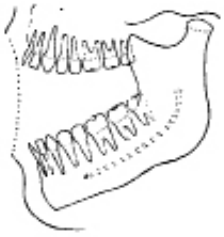

LEFT

Please email any relevant images (including panoramics, CT, periapicals, bitewings) to **omps@uw.edu**. Please use 'Biopsy Images' in the subject line, and include patient's name in the body of the message.

UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY
ORAL AND MAXILLOFACIAL PATHOLOGY SERVICE

~ AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION AND RECORD ~

In order to comply with Washington state laws regarding confidentiality, the School of Dentistry, Oral and Maxillofacial Pathology Service (OMPS) must have your written permission to release information. Under the Health Insurance Portability & Accountability Act (HIPAA), all healthcare facilities are required to have several area of the form completed in full. If any of the required elements (noted by "") are not completed in full, this authorization request becomes invalid, and must be returned to you for proper completion.*

1. Patient Information *

Patient Name:	
Patient Account #:	
Birth Date:	
Patient Address:	
Telephone #:	

2. Health Information to be Disclosed *

- ☐ Laboratory and/or Consultation Reports
- ☐ Billing and Insurance Information
- ☐ Other: _____

3. Health Information Period for Disclosure *

- ☐ Prior 2 years
- ☐ Prior 5 years
- ☐ Other: _____

4. My Revocation Rights

I understand that I have a right to revoke this authorization in writing at any time except:

- When the OMPS has already taken action based on this authorization or
- Where authorization was required for my insurance coverage.

5. Authorization Expiration

Unless revoked by me, I understand that this authorization will expire in ninety (90) days from the date of my signature below or from _____ (no more than 90 days from the date signed) except under the following situation:

- Authorizations given to provide information to a third-party payer or
- Agreement with a disciplinary authority.

6. My Rights

I understand that I do not have to sign this authorization in order to receive health care treatment or obtain health care payment benefits except for the following situation:

- I am taking part in a research-related treatment program or study where OMPS requires such or
- I am receiving health care from OMPS soley for the purpose of creating health care information for a third party.

I further understand that once my health information has been disclosed by the OMPS, the recipient may re-disclose my health information, and it will no longer be protected under the health privacy laws. I release the University of Washington, School of Dentistry staff and counsel from all responsibility or liability that may arise from authorized release of information.

7. Health Information / Record Recipient *

I hereby authorize the Oral and Maxillofacial Pathology Service at the University of Washington to discuss and release all related patient's health information to the recipient(s) listed below, for the following purpose(s):

☐ Healthcare ☐ Legal ☐ Insurance/Billing ☐ Other (describe): _____

Recipient's Name / Organization:	
Recipient's Mailing Address:	
Recipient's Telephone #:	

Patient or legally authorized individual signature *

Date & Time *

Printed Name *

Relationship (if requester is other than patient) *

Patient Account Number *

Social Security Number

RESET FORM