



# TISSUE PROCESSING REQUEST

## Bill

MEDICARE   
  PRIVATE INSURANCE   
  DOCTOR   
  PATIENT

Medicare Number / ID Number

Secondary Insurance Information (Please attach card)

**Histopathology  
Reference Laboratory**

710 Alfred Nobel Drive, Hercules CA 94547

Patient Name      last                      first                      middle int.

Address

City                                      State                                      Zip

Daytime Telephone                      Sex                      Birthdate

Doctor Name

**Please Attach a Copy of Medicare / Insurance Card**

I hereby authorize payment of medical benefits to HRL and the release of any information required to process my claim.

DATE SPECIMEN TAKEN

/ /

Patient Signature

Date

Location of  
Tissue Submitted

Procedure Code

88304

88305

Diagnostic  
Code

#1

#2

#3

#4

#5

#6

LABORATORY = WHITE COPY • PHYSICIAN = YELLOW COPY