



THE RAPATH

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\*REQUIRED FIELD

SPECIMEN COLLECTION

DATE \_\_\_\_\_ TIME \_\_\_\_\_

REQUISITION FOR (ENFD) EPIDERMAL NERVE FIBER DENSITY & AMYLOID STAIN TEST

SUBMITTING FACILITY

Ordering MD: \_\_\_\_\_ Contact Person: \_\_\_\_\_
Practice Name: \_\_\_\_\_ Telephone: \_\_\_\_\_
Address: \_\_\_\_\_ Fax: \_\_\_\_\_
City/State: \_\_\_\_\_ Medical Center Affiliation: \_\_\_\_\_
E-mail: \_\_\_\_\_ NPI #: \_\_\_\_\_

PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SS #: \_\_\_\_\_
Address: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Sex: [ ] Male [ ] Female
Telephone: \_\_\_\_\_
Cell Number: \_\_\_\_\_
PCP Name: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

CLINICAL INFORMATION

DIAGNOSIS CODES; 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

CLINICAL HISTORY \_\_\_\_\_

BIOPSY LOCATIONS

Calf - 10 cm above lateral malleolus
Thigh - at the level of the pubis
Foot - dorsum of the foot at the extensor digitorum brevis muscle

Table with 6 columns: Sample location (A, B, C, D), left, right, calf, thigh, foot. Each cell contains a checkbox.

PATIENT INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_
ID/Subscriber/Policy #: \_\_\_\_\_ ID/Subscriber/Policy #: \_\_\_\_\_
Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_
Insured's Name: \_\_\_\_\_ Insured's Name: \_\_\_\_\_
Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Authorization to Release Information and Pay Benefits: I consent to have testing services performed on my sample that is being sent to Therapath. I authorize Therapath to provide my insurance company with all of the necessary information, including test results, that is needed to receive payment for my laboratory tests. I also authorize that benefits under this claim be payable directly to Therapath. I agree to submit within 15 days, to Therapath, any payment for these laboratory services that were made directly to me. I authorize Therapath to file any appeal, grievance or claim review to my insurance carrier on my behalf.

I agree and acknowledge that if I do not have applicable insurance coverage or my insurance company denies coverage for services rendered by Therapath, LLC, I will be personally responsible for payment to Therapath, LLC for such services. I further agree and acknowledge that any court action between Therapath, LLC and myself, including, but not limited to, issues relating to payment shall be brought in a court of appropriate jurisdiction in Bergen County, New Jersey. Therapath, LLC may, in its sole discretion, choose to bring any such action in the jurisdiction in which I reside.

Therapath Use
CI \_\_\_\_\_ AN \_\_\_\_\_ AT \_\_\_\_\_ FE \_\_\_\_\_

Patient Signature: \_\_\_\_\_
\*REQUIRED FIELD