



Dermatopathology Service
Department of Dermatology

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Director of Dermatopathology

Accession Number - Mayo Clinic Use Only

Number (above) and Name

Patient Name _____ Collection Date _____

Date of Birth _____ Social Security Number _____ Male Female

Address _____

City _____ State _____ Zip Code _____

Referring Physician Name _____ NPI Number _____

Referring Physician Address _____

Referring Physician Phone Number _____ Fax Number _____

Payer Patient Insurance

Medicare Primary Secondary Medicare (HIC) Number _____

(include alphanumeric characters)

Other Ins. Primary Secondary

Name of Insured _____ Patient Spouse Parent/Guardian

Name of Insurance Company _____

Policy Number _____ Group Number _____ Insured DOB _____

Address _____

City _____ State _____ Zip Code _____

Please include copies of patient's insurance card (front and back).
Call or refer to website for a list of contracted payers.

Site	Procedure Type	Clinical Impression
	S=Shave, P=Punch, E=Excision, R=Re-excision	
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Additional History or Comments (if applicable) _____

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