Arkana Laboratories

Epidermal Nerve Fiber Density Requisition Form

Affix patient sticker here

Patient Information:

Patient Name: _____ Social Security #: _____ Gender: ☐ M ☐ F

Date of Birth (MMDDYYYY): _____ Phone #: _____ Marital Status: ☐ Married ☐ Single ☐ Other

Address: _____ City: _____ State: _____ Zip Code: _____

Spouse Name: _____ Social Security #: _____ Date of Birth (MMDDYYYY): _____

Clinical Information:

Surgical Number: _____ Biopsy site: _____ Biopsy Date: _____

Working/suspected clinical diagnosis/differential: _____

Clinical history, patient pertinent current and prior history, and pertinent physical exam findings attach additional sheets as needed: _____

_____

Referring Physician:

Treating Physician; Neurologist, Podiatrist, Dermatologist (**Required information**) : _____

Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Surgeon performing biopsy: _____ Phone #: _____ Fax #: _____

Third-Party Billing Information: Complete or attach a copy of insurance card and authorization

Insured/Responsible Party: _____ Date of Birth (MMDDYYYY): _____ Gender: M F

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Member ID #: _____ ☐ Medicare ☐ Medicaid ☐ HMO ☐ PPO ☐ Other

Policy #: _____ Group #: _____

Insurance Co Name: _____ Insurance Co Address: _____ Insurance Co Phone #: _____

Employer Name: _____ Employer Phone #: _____

Referral Authorization/Precertification #: _____

Print Name: _____ Signature: _____ Date: _____

10810 Executive Center Drive, Suite 100 Little Rock, Arkansas 72211
Telephone +1 501 604 2695 Fax +1 501 604 2699 support@arkanalabs.com
arkanalabs.com