

ANATOMIC PATHOLOGY CONSULT REQUISITION

 UI Diagnostic Laboratories
 Department of Pathology
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FOR CLIENT USE ONLY: Requisition Date: _____ Completed By: _____ Accn# _____	FOR UIDL USE ONLY: UIDL Path # _____ UIDL MRN# _____
PART A - PATIENT INFORMATION - <i>Required</i>	PART B - PROVIDER INFORMATION - <i>Required</i>
Patient Name: _____	Referring Institution: _____
Street: _____	Street: _____
City: _____ St: _____ Zip: _____	City: _____ St: _____ Zip: _____
Phone: () _____	Phone: _____ Fax: _____
Date of Birth: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Referring Physician: _____
	Referring Physician NPI: _____

PART C - SPECIMEN INFORMATION (Complete the appropriate information below or include in an accompanying letter.)

MATERIALS SUBMITTED: _____ SLIDES* _____ BLOCKS* _____ WET TISSUE _____ FROZEN TISSUE _____ OTHER _____ Specify source below
Required ICD-9 codes: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

TISSUE SOURCE/SITE: _____ **DATE OF COLLECTION:** _____

CONSULTATION REQUESTED: (All consultations include interpretation) *Please include a copy of your report*

- | | | |
|---|--|---|
| <input type="checkbox"/> BONE MARROW/HEMATOLOGY | <input type="checkbox"/> ELECTRON MICROSCOPY | <input type="checkbox"/> NEUROPATHOLOGY |
| <input type="checkbox"/> CYTOPATHOLOGY | <input type="checkbox"/> IMMUNOPATHOLOGY | <input type="checkbox"/> RENAL PATHOLOGY |
| <input type="checkbox"/> DERMATOPATHOLOGY | <input type="checkbox"/> MOLECULAR PATHOLOGY | <input type="checkbox"/> SURGICAL PATHOLOGY |

 Physician signature

 Date

PERTINENT CLINICAL HISTORY AND FINDINGS: _____

CLINICAL DIFFERENTIAL DIAGNOSIS: _____

PREVIOUS TESTS RELEVANT TO CURRENT PROBLEM (e.g. Prior tissue, abnormal cytology examination, recent CBC, etc...)

LIST CYTOLOGY SPECIMENS AND COLLECTION METHOD (e.g. brush, wash, catheterized, void): _____

PART D - SEND BILL TO:	<input type="checkbox"/> Referring Institution Contact: _____ Address: _____ City, St, Zip code: _____
	<input type="checkbox"/> Patient's Insurance (Complete billing information must be provided or referring institution may be billed)
Primary Insurance Coverage Information	Secondary Insurance Coverage Information
Insured by: _____	Insured by: _____
Claims Address: _____	Claims Address: _____
City: _____ ST: _____ ZIP: _____	City: _____ ST: _____ Zip: _____
Policy/ID #: _____ Group #: _____	Policy/ID #: _____ Group #: _____
Name of Subscriber: _____ DOB: _____	Name of Subscriber: _____ DOB: _____
Relationship to Patient: _____	Relationship to Patient: _____

 Please note that the correct birth date of all policy holders is required information. Please attach the following to the requisition:

- (1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage.
OR
- (2) a printout with patient demographics and insurance information from your practice management system.

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.