

Renal Pathology Requisition

FOR UIDL USE ONLY: MRN# _____	PATH# _____
FOR CLIENT USE ONLY: Requisition Date _____	Completed by: _____
SPECIMEN INFORMATION - REQUIRED	
STATUS: <input type="checkbox"/> STAT <input type="checkbox"/> ROUTINE Has the patient had a RENAL TRANSPLANT? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____	
Please check all testing you are requesting: <input type="checkbox"/> LM, IF, + EM <input type="checkbox"/> IF & EM <input type="checkbox"/> EM only <input type="checkbox"/> C4d <input type="checkbox"/> BK Virus	
SPECIAL INSTRUCTIONS:	
Specimen Source: <input type="checkbox"/> Left Kidney <input type="checkbox"/> Right Kidney Collection Date: ___ / ___ / ___ <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient	
Specimen(s): <input type="checkbox"/> Formalin Vial <input type="checkbox"/> Michel's Vial <input type="checkbox"/> Glutaraldehyde Vial <input type="checkbox"/> Slides <input type="checkbox"/> Paraffin Block	
Required ICD-10 Code(s): 1) 2) 3) 4)	
PATIENT INFORMATION - please print	
Legal Name: _____	DOB: _____ Male Female
Address: _____	
City: _____	State: _____ Zip: _____
Phone: _____	
NEPHROLOGIST TO CALL WITH BIOPSY RESULTS - REQUIRED	
Ordering Nephrologist Name: _____	
Nephrologist Cell: _____	Office: _____ FAX: _____
Group Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
REFERRING INSTITUTION OR PATHOLOGY GROUP:	
Institution/Path Group Name: _____	
Pathologist Name: _____	
Phone: _____	FAX: _____
Address: _____	
City: _____	State: _____ Zip: _____
SEND BILL TO - REQUIRED	
<input type="checkbox"/> Bill Referring Physician/Institution <input type="checkbox"/> Bill Patient's Insurance - If checked and patient has no insurance the referring physician will automatically be billed.	
INSURANCE INFORMATION:	
Primary Insurance: _____	Phone: _____
Address: _____	
City: _____	State: _____ Zip: _____
Policy Holder's Name: _____	Policy ID #: _____
Group Name: _____	Group #: _____
Secondary Insurance: _____	Phone: _____
Address: _____	
City: _____	State: _____ Zip: _____
Policy Holder's Name: _____	Policy ID #: _____
Group Name: _____	Group #: _____
MEDICARE:	
Medicare #: _____	Group #: _____ Effective Date: _____
MEDICAID:	
Medicaid #: _____	Benefit Type: _____ Effective Date: _____

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 customary" under the Medicare Standards, Medicare will deny payment for that service or test.