Indiana University Health

IU Health System Pathology Laboratories
350 W. 11th Street, Room 5013
Indianapolis, IN 46202-4108
317.491.6000 or 800.433.0740
Fax: 317.491.6001

1) Patient Legal Name (Last, First MI)		DOB	2) ( ) STAT	Date/Time of Collection
Patient Social Security #	Race	MR#/Alternate Pt ID		Phone Results To:
Patient Address		Phone		Fax Results To:
City, State, Zip		M F	4) **BILL PATIENT/INSURANCE COMPANY**	
3) Physicians Signature	Order Date	Print Physicians Name (F,MI,L)	ATTACH A COPY OF FACE SHEET AND INSURANCE CARD - ALL required (highlighted) fields must be complete to bill patient's insurance company. Specimen will be registered as patient self-pay and bill will be the responsibility of the patient if required information is not provided.	

Client (Clinic/Physician) Information	Group Physicians	Primary Insurance
		Company Name:
		IU/Policy# Group #/Name:
		Insurance Co. Address:
Send Additional Report To:		City: State/Zip:
		Policy Holder Name:
		Relationship to Patient:

Notice: Medicare will only pay for tests that meet the Medicare definition of "Medical Necessity". Medicare may deny payment for a test that the physician believes is appropriate, such as a screening test. If a test is being ordered as a screen, be certain the patient has signed the Advanced Beneficiary Notice (ABN) located on back of this requisition.	5) ICD Diagnosis Codes (Enter ALL that apply)		*1*	*2*	*3*
	4	*5*	*6*	*7*	*8*

Surgical Pathology

Pre-OP Diagnosis Indications:_____

_____

Procedure:_____

Post-OP DX:_____

Remarks:_____

_____

History:_____

Previous Surgery:_____

Date(s):_____

Tissue Submitted: (Please print. Do Not Abbreviate.)

A	FS □	J	FS □
B	FS □	K	FS □
C	FS □	L	FS □
D	FS □	M	FS □
E	FS □	N	FS □
F	FS □	O	FS □
G	FS □	P	FS □
H	FS □	Q	FS □
I	FS □	R	FS □