Washington University Physicians®

PATHOLOGY: Electron Microscopy

Ship samples to:

Washington University Pathology Services
Attn: EM Facility
425 S. Euclid Ave. | MSC 8024-14-04
St. Louis, MO 63110
Tel: (314) 747-1100 | Fax: (314) 362-4096

Office use only
Date/Time Received:
Accession Number:
Technician Initial:
Received:

This requisition has two pages, please complete it completely and accurately.

PATIENT IDENTIFICATION				PHYSICIAN ORDER TEST *(NPI required)*		
Name Last:	First:		MI:	Name Last:	First:	MI:
DOB (mm/dd/yyyy):	Sex:	☐ Male: ☐ Female:		NPI:	Email:	
Medical Record # (if applicable):				Phone:	Fax:	
				Pager:		
Address:				Address:		
City:	State:	Zip:		City:	State:	Zip:

SPECIMEN INFORMATION

Date of biopsy:	Type of biopsy:	Outside case number:
Tissue submitted in	☐ Karnovsky's fixative	☐ Paraffin block
	☐ 10% formalin	☐ Other:

REASON FOR TESTING *(required)*

Diagnosis:

ICD10 Code(s):

TESTING REQUESTED *(check all that apply)*

☐ Routine electron microscopic service with interpretation
☐ Technical only (no interpretation)

Email to deliver images to:

☐ Embed in plastic resin and hold*
☐ Embed in plastic resin with toluidine blue stained sections*

**Institutional billed services only. Please supply correct information on page 2 in order to prevent delays.*

ADDITIONAL NOTES:

Healthcare Professional Signature to Authorize Testing and Statement of Medical Necessity
I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

Signature:
Date:

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):

INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at (314) 362-5641 or via email at path-billing@email.wustl.edu for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):
CPT Codes and Units Authorized:	

ATTACH COPY OF INSURANCE CARD (if not available, complete the following)

Policy Holder's Name: Last First MI	Insurance Co. Name:	
Policy Holder's Date of Birth (mm/dd/yyyy):	Insurance Co. Phone:	
Relationship to patient:	Plan Name:	
	ID#:	Group#:

SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our Patient Accounts Manager office at (314) 362-5641 or via email at path-billing@email.wustl.edu.

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

Institution Name:		
Contact Name:		
Email:		
Billing Address:		
City:	State:	Zip:
Phone:	Fax:	