

Ship samples to:
Washington University Pathology Services

Clinical Support Office
425 S. Euclid Ave. | MSC 8024-14-04
St. Louis, MO 63110
Tel: (314) 747-1100 | Fax: (314) 362-4080

Office use only

Date/Time Received:
Accession Number:
Technician Initial:
Received: Formalin (LM): Other:
Number of Specimens:

This requisition has two pages, please complete both pages to ensure testing.

PATIENT IDENTIFICATION			PHYSICIAN ORDERING TEST <i>(NPI required)</i>		
Patient Status: ☐ Inpatient ☐ Outpatient ☐ Office Visit			Name:		
Name Last: last name first page	First: first first page	MI:	Institution:		
DOB (mm/dd/yyyy):	Sex: ☐ Male ☐ Female		NPI:	Email: doc email	
Medical Record # (if applicable):			Address: doc address		
Address: address first page			City: doc city	State: doc state	Zip: doc zip
City: city first page	State: first page	Zip: first page	Phone: phone	Fax:	
Ethnicity (select all that apply)			Alternative Contact Information:		
☐ African American ☐ Asian ☐ Caucasian/NW European ☐ E Indian ☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic ☐ Mediterranean ☐ Native Hawaiian/Pacific Islander ☐ Other			Phone: doc phone		Email: doc email
			Notes:		

REASON FOR TESTING AND CLINICAL HISTORY

(failure to include diagnosis and relevant ICD10 codes may delay testing)

Diagnosis:

ICD10 Code(s):

Clinical History

Does patient have metastatic disease? ☐ Yes ☐ No ☐ Unknown ☐ Not Relevant

OB/GYN	Last Menses:	Date Ovulation:	G:	P:	AB:	Hormone Rx:
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SPECIMEN INFORMATION

Operative Procedure and Findings:

Number of specimens submitted (containers):	Time placed in fixative:
Specimens	Site of biopsy
1.	
2.	
3.	
4.	
5.	

ADDITIONAL COMMENTS:
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):
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BILLING INFORMATION (CHECK ONE)

☐ Bill Patient/Insurance-Complete Section A

☐ Bill Submitting Institution-Complete Section B

SECTION A-PATIENT/INSURANCE BILLING INFORMATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. For MEDICAID patients, Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered services. 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):
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CPT Codes and Unit Authorized:

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

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

SECTION B-INSTITUTIONAL BILLING

Institution Name:		
Contact Name:	PO Number (if applicable):	
Email:		
Accounts Payable Billing Address:		
City:	State:	ZIP:
Phone:	Fax:	