# **PATHOLOGY: Tissue Exam**

### 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): 0

Other:

Number of Specimens:

	Th	is requ	uisition h	as two p	ages, pleas	e complete it c	ompletely and	d accurat	ely.			
PATIENT IDENTIFICATION					PHYSICIAN ORDER TEST (NPI required)							
Name Last:		First:			MI:	Name Last:			First:			MI:
DOB (mm/dd/yyy	n/dd/yyyy): Sex: □ Male □Femal		□Female	!	NPI:		Email:					
Medical Record # (if applicable):						Phone: Fax:						
						Pager:						
Address:						Address:						
City:		State:		Zip:		City:			State:		Zip:	
		(failt				AND CLINICAL evant ICD10 code		esting)				
Diagnosis:												
CD10 Code(s):												
Clinical History												
Does patient have metastatic disease? ☐ Yes ☐ No					□ Unknown □ Not Relevant							
OB/GYN	Last Menses: Date Ovulation:			G:	P:	AB:	AB:		Hormone Rx:			
				9	SPECIMEN IN	NFORMATION						
Operative Proced	lure and Findings:											
Number of specimens submitted (containers):						Time placed in fixative:						
Specimens					Site of biopsy							
1.												
2.												
3.												
4.												
5.												
ADDITIONAL C	OMMENTS:					1						

### 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,	/уууу):					
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 <a href="mailto:path-billing@email.wustl.edu">path-billing@email.wustl.edu</a> 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		Insurance Co. Name:							
Holder's Last Fi	rst MI	Insurance Co. Phone:							
Policy Holder's Date of Birth (mm/dd/yyyy):		Plan Name:							
Relationship to patient:		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 <a href="mailto:path-billing@email.wustl.edu">path-billing@email.wustl.edu</a> .									
•••••••	• • Reference Laboratories:		•••••	••••••					
INSTITUTIONAL BILLING									
Institution Name:									
Contact Name:									
Email:									
Billing Address:									
City:		State:	Ī	Zip:					
Phone:		Fax:							