University of Miami Miller School of Medicine

PATHOLOGY SPECIALTY SERVICES

UHealth Laboratories

1400 NW 12th Avenue, Suite 4076, Miami Florida 33136 Ph. (305) 243-7284
(800) 445-3074 Fax: (305) 689-7284

Pathology Request Form

Accession No _____
Received by _____
Date _____ Time _____ am/pm

ATTENTION HEALTH CARE PROVIDERS

Medical Necessity: Federal regulators require that only tests that are necessary for diagnosis and treatment of a patient's condition be ordered.

ICD-9 Code is **required** to prove medical necessity of outpatient's. Dr.'s name, phone number and ICD-9 Code are **absolutely required**.

PATIENT INFO: PLEASE PRINT ALL OF THE FOLLOWING INFORMATION

Last Name: _____ First name: _____ Client No. _____ Phone No. _____

Address: _____

City: _____ State: _____ Zip: _____

SS #: _____ - _____ - _____ Phone No. _____

Date of Birth: _____ / _____ / _____ Sex: ☐ M ☐ F

Medical Record # : _____

SPECIMEN INFORMATION

Collection Date: _____/_____/_____ Time Ordered: _____ am / pm

Collected by: _____ Specimen Source: _____

Fixative: _____ Fixation Time: _____

Test Order Date: _____ / _____ / _____

ATTENDING PHYSICIAN INFORMATION (PLEASE PRINT LEGIBLY)

Ordering M.D. **Name:** _____

Ordering M.D. **Signature:** _____

Ordering M.D. **NPI #:** _____ **Beeper/Ph:** _____

Diagnosis _____

ICD 9 Codes: _____

☐ **Bill Insurance**

☐ **Bill Client/Referring Institution**

PATIENT INSURANCE INFORMATION (IF APPLICABLE)

INSURED: _____

Insurance Co.: _____

Policy #: _____ Medicare #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ Fax: ( ) _____

Relationship to Insured: _____

PRE OP DX:

POST OP DX:

**** PLEASE INCLUDE BILLING FACE SHEET ****

BRIEF CLINICAL HISTORY / DIAGNOSTIC PROBLEMS / ICD-9:

LAB USE ONLY

ALL FIELDS MUST BE COMPLETED. LABORATORY TESTING WILL NOT BE PERFORMED IF INCOMPLETE FORMS ARE RECEIVED.

FL AHCA: 8000015642	Provider: L9260	**I hereby authorize this request for professional services to be rendered and billed by the above captioned laboratory.**
CLIA: 10D0976961	External Billing Area: PPSEC 1307	
Medicare: L9260	Internal Billing Area: PPSIC 1308	**I further authorize the release of any medical information required by insurance carrier or MEDICARE carrier.**
Medicaid: 05-7829100	Tax ID No.: 59-2695890 Facility: PSS	Distribution: White - Billing Yellow - Lab Pink - Client / Rev. 05/09 Signature: