UJHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM
Lab System

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

University of Miami Medical Laboratories
PATHOLOGY SPECIALTY SERVICES

UM/JM Medical Center
1400 NW 12th Avenue, 4th Floor, Room 4076 • Miami, Florida 33136
Phone (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 outpatients. 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:_____
Address:_____
City:_____ State:_____ Zip:_____
SS#: _____ - _____ - _____
Date of Birth: _____/_____/_____ Sex: M☐ F☐

Client. No.

Telephone

Medical Record # _____

SPECIMEN INFORMATION

Collection Date: _____/_____/_____ Time:_____ am / pm
Collected By:_____ Specimen Source:_____
Fixative:_____ Fixation Time:_____
Test Order Date: _____/_____/_____

PATIENT INSURANCE INFORMATION (IF APPLICABLE)

INSURED:_____
Insurance Co.:_____
Policy#:_____ Medicare #:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone: ( )_____ Fax: ( )_____
Relationship to Insured:_____

ATTENDING PHYSICIAN INFORMATION (PLEASE PRINT LEGIBLY)

Ordering M.D. **Name:**_____
Ordering M.D. **Signature:**_____
Ordering M.D. **NPI #:**_____ **Beeper/Ph:**_____
Diagnosis_____
ICD 9 Codes:

PRE OP DX:

POST OP DX:

BRIEF CLINICAL HISTORY / DIAGNOSTIC PROBLEMS / ICD-9:

LAB USE ONLY

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

FLAHCA: 800015642	Provider: L9260	
CLIA: 10D0976961	External Billing Area: PPSEC 1307	
Medicare: L9260	Internal Billing Area: PPSIC 1308	
Medicaid: 05 7829100	Tax ID No.: 59-2695890	Facility: PSS

I hereby authorize this request for professional services to be rendered and billed by the above captioned laboratory. I further authorize the release of any medical information required by insurance carrier or MEDICARE carrier.

Distribution: White—Billing Yellow—Lab Pink—Client / Rev.05/09 **Signature :**