THE UNIVERSITY OF CHICAGO MEDICINE

UChicago MedLabs Department of Pathology
5812 South Ellis Avenue
Room J601, MC-6101, Chicago, IL 60637
Phone 773-702-3611 Fax 773-702-4633

UChicago MedLabs

^ ***Place CoPath Label Here*** ^

1. PATIENT INFORMATION – Required

Name _____

DOB _____ Sex Male SS# _____

Street _____

City _____ State _____ Zip _____

Phone _____

2. CLIENT INFORMATION - Required

Institution/Group Practice: _____

Address: _____

City:_____ State:_____ Zip: _____

Phone: _____ Fax:_____

_____ _____
Requesting Pathologist NPI

_____ _____
Ordering Physician NPI

3. BILLING CLASSIFICATION: Check only one box. If no box is checked, UChicago MedLabs will bill Client.
Please see Requisition Form Instructions for additional information.

BILL CLIENT

- ◯ (a) Original material from a hospital inpatient
- ◯ (b) 2nd opinion requested by Client's pathology department
- ◯ (c) Medicare Inpatient Exception (technical fee billed to Client, professional fee billed directly to Medicare) Complete Box 4

BILL PATIENT INSURANCE Please check for HMO authorization.

- ◯ (d) Original material from hospital outpatient Complete Box 4
- ◯ (e) 2nd opinion requested by patient's clinician Complete Box 4
  Ordering Physician: _____
  NPI: _____
- ◯ (f) 2nd opinion requested by the University of Chicago Medical Center
  Ordering Physician _____
  Department _____

4. PATIENT INSURANCE INFORMATION * * Please attach a copy of the front/back of patient's insurance card(s) * *

_____ _____ _____ _____
Subscriber (if different from patient) DOB Relationship SS#

Primary Insurance Co. _____

_____ _____
Policy Number Group Number

_____
Insurance Company Address

Secondary Insurance Co. _____

_____ _____
Policy Number Group Number

_____
Insurance Company Address

5. CONSULTATION REQUESTED: (Includes interpretation)

Neuro Path ◯ Nerve ◯ Muscle
- ☐ Electron Microscopy
- ☐ Light Microscopy
- ☐ Other

Renal Biopsy ◯ Native ◯ TX
- ☐ Electron Microscopy
- ☐ Light Microscopy
- ☐ Immunofluorescence

Heart Biopsy ◯ Native ◯ TX
- ☐ Electron Microscopy
- ☐ Immunofluorescence
- ☐ Immunohistochemistry

☐	Esophageal / Gastric	☐	FNA, Source _____	OTHER (Please specify) _____
☐	Hematopathology	☐	Electron Microscopy (Non-Renal)	_____

PLEASE COMPLETE THE APPROPIATE INFORMATION BELOW (Include copies of previous reports)

6. SPECIMEN TYPE: ☐ SLIDES # _____ ☐ BLOCKS # _____ ☐ FIXED FORMALIN ☐ GLUTERALDEHYDE
☐ MICHELLES/ZEUS ☐ FROZEN TISSUE ☐ OTHER _____

Date material was removed from archive: _____ slides _____ blocks

7. TISSUE SOURCE _____ Date of Collection _____ Accession #_____

8. PERTINENT CLINICAL HISTORY AND FINDINGS: (Including previous tests results) _____

_____

_____

9. Medical Necessity Requirement ICD10 CODES: _____ _____ _____ _____

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare standards, Medicare will deny payment for that service or test.

Print Form