



Oregon Health Sciences University Hospitals and Clinics

REFERENCE LABORATORIES REQUISITION

(SEE REVERSE SIDE FOR MAILING ADDRESSES AND TELEPHONE NUMBERS)

PATIENT INFORMATION

PATIENT LAST NAME	FIRST	MI	SEX	BIRTH DATE	SOCIAL SECURITY NO (REQUIRED)
LABORATORY ACCESSION NO./ PATIENT IDENTIFICATION NO.			DATE COLLECTED	TIME COLLECTED	INPATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO

TESTING INFORMATION

TEST NAME(S) _____ _____	**REQUIRED**ICD-9 DIAGNOSIS CODE(S) _____ _____
SPECIMEN SOURCE _____	CLINICAL INDICATION/HISTORY _____
CURRENT DRUG Rx _____ TOTAL SPECIMEN VOLUME _____	DATE ONSET PRESENT ILLNESS _____ DATE ONSET SIMILAR _____
IF PREGNANCY RELATED SERVICE: PREGNANT Y / N , LMP _____ ESTIMATED DUE DATE _____	

REFERRING LABORATORY/PHYSICIAN (CLIENT) INFORMATION

NAME		PHONE	FAX	
ADDRESS		CITY	STATE	ZIP
REQUESTING PHYSICIAN		UPIN (REQUIRED FOR MEDICARE)		PHONE
ADDITIONAL REPORT TO	NAME			
	ADDRESS	CITY	STATE	ZIP

BILLING INFORMATION

BILLING IS DONE IN ACCORDANCE WITH THE INFORMATION PROVIDED BELOW AND OHSU POLICY (SEE REVERSE) APPROPRIATE AREAS MUST BE COMPLETED OR REFERRING LABORATORY / PHYSICIAN WILL BE BILLED.

REFERRING LABORATORY / PHYSICIAN (CLIENT)						
PATIENT'S UNIVERSITY ACCOUNT FOR CYCLOSPORINE / FK506 TESTING						
PATIENT	MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE	
THIRD PARTY	PRIMARY PREAUTHORIZATION NUMBER _____ INSURANCE COMPANY _____ POLICY NUMBER _____ GROUP NUMBER _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____ SUBSCRIBER NAME _____ DOB _____ SEX _____		SECONDARY PREAUTHORIZATION NUMBER _____ INSURANCE COMPANY _____ POLICY NUMBER _____ GROUP NUMBER _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____ SUBSCRIBER NAME _____ DOB _____ SEX _____			
	MEDICAID/ OHP	POLICY NUMBER _____ PREAUTHORIZATION NUMBER _____	STATE (if other than Oregon) _____			
	MEDICARE	POLICY NUMBER _____	IS THIS PRIMARY _____ OR SECONDARY _____ IF SECONDARY, PROVIDE INSURANCE INFORMATION ABOVE If Medicare determines that a particular service is for screening purposes or is not reasonable and necessary under Medicare program standards, Medicare will deny payment for that service. If this is the case, I agree to be personally and fully responsible for payment. SIGNATURE: _____			
	RESPONSIBLE PARTY (GUARANTOR) NAME _____					
SOCIAL SECURITY NUMBER _____		RELATIONSHIP TO PATIENT _____	DATE OF BIRTH _____	SEX _____		
ADDRESS _____		CITY _____	STATE _____	ZIP _____		

Ophthalmic Pathology CEI
Casey Eye Institute
3375 SW Terwilliger
Portland, OR 97239
Phone: (503) 494-7881

Pre-Natal Diagnosis CDRC
Child Development & Rehabilitation Center
707 SW Gaines Rd, Rm. 2279
Portland, OR 97239
Phone: (503) 494-7577

Surgical Pathology L471
3181 SW Sam Jackson Park Rd
Dillehunt Hall Rm. 5022
Portland, OR 97239
Telephone: (503) 494-6775
Specialties Include:
Cytology 494-8278
Immunohistochemistry 494-5775
Electron Microscopy 494-8402

Lab Medicine L471
3181 SW Sam Jackson Park Rd
Dillehunt Hall Rm. 3020
Portland, OR 97239
Phone: (503) 494-7383

Specialties Include:
Hemostasis & Thrombosis 494-8445
Immunology 494-2302
OHSU/VAMC Joint Flow Cytometry 494-2302
Hematopathology 494-2302
Occupational & Environmental Allergy 494-7743

Genetics Laboratories MP350
2525 SSW 3rd Avenue, Suite 350
Portland, OR 97201-4950
Phone: (503) 494-5400
Specialties Include:
Biochemical Genetics 494-2404 (after hours)
Cytogenetics 494-2790 (after hours)
DNA Diagnostics 494-7465 (after hours)

Oregon Health & Science University
Hospitals and Clinics Laboratories
3181 S.W. Sam Jackson Park Rd., Portland OR 97239
(503) 494-7383

BILLING POLICY FOR UNIVERSITY REFERENCE LABORATORIES

OHSU Hospital Laboratories must receive complete information on the Reference Laboratories Request form at the time of specimen receipt. Failure to provide this information will result in the client being billed.

Client Billing: University Hospital will bill the hospital, reference laboratory, clinic or individual physician. Terms of payment are net 30 days.

University Hospital will bill the client if the patient is hospitalized at the time of specimen collection.

Patient Billing: If payment for a service rendered is to be responsibility of the patient, prepayment is requested. Exception: Reflex testing will be billed to the patient.

Third Party Billing: University Hospital will bill third party payors. Patients will be billed for balances not covered by their insurance. Complete all shaded areas of the Reference Laboratory Request form that pertain to Third Party Billing. If the required information is not provided at the time of specimen receipt, the client will be billed.

Medicare / Medicaid: University Hospital will bill Medicare and Medicaid. Complete all shaded areas of the Reference Laboratories Request form that pertain to Medicare / Medicaid Billing. If the required information is not provided at the time of specimen receipt, the client will be billed.
Physician UPIN number and ICD9 code are required.
Completed Medical Necessity ABN form and Medicare as Secondary Payor forms must accompany specimen when required.

Cyclosporine and FK506 Testing ONLY: University Hospital will bill the current individual patient's account. The patient may obtain an account number by calling (503) 494-8505.