Oregon Health & Sciences University
Hospitals and Clinics

REFERENCE LABORATORIES REQUISITION

Clinical Genetics Labs Shipping Address:
2525 SW 3rd Ave **MP 350**
Portland, OR 97201
Ph 503-494-5400 Fax 503-494-6922

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 YES NO

TESTING INFORMATION

TEST NAME(S)_____

_____

SPECIMEN SOURCE _____

CURRENT DRUG Rx _____ TOTAL SPECIMEN VOLUME_____

IF PREGNANCY RELATED SERVICE: PREGNANT Y / N , LMP_____ESTIMATED DUE DATE_____

****REQUIRED**ICD-9 DIAGNOSIS CODE(S)**_____

_____

CLINICAL INDICATION/HISTORY _____

DATE ONSET PRESENT ILLNESS_____DATE ONSET SIMILAR_____

REFERRING LABORATORY/PHYSICIAN (CLIENT) INFORMATION

NAME	PHONE	FAX	
ADDRESS	CITY	STATE	ZIP
REQUESTING PHYSICIAN	**NPI** (REQUIRED)	PHONE	

ADDITIONAL REPORT TO	NAME			
	ADDRESS	CITY	STATE	ZIP

SELECT ONE BILLING METHOD BELOW

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 — 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 _____ STATE (if other than Oregon) _____
PREAUTHORIZATION NUMBER _____

☐ 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 _____ Phone: _____