



# OHSU Healthcare

## LABORATORY TESTING REQUISITION

Main Mailing Address: 3181 S.W. Sam Jackson Park Rd., L471, Portland, OR 97239-3098, Phone: 503-494-7383

(See next page for additional 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		NPI (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 NEXT PAGE) APPROPRIATE AREAS MUST BE COMPLETED OR REFERRING LABORATORY / PHYSICIAN WILL BE BILLED.**

<input type="radio"/>	REFERRING LABORATORY / PHYSICIAN (CLIENT)					
<input type="radio"/>	PATIENT	MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE
<input type="radio"/>	THIRD PARTY	<b>PRIMARY</b>		<b>SECONDARY</b>		
		PREAUTHORIZATION NUMBER _____	PREAUTHORIZATION NUMBER _____			
		INSURANCE COMPANY _____	INSURANCE COMPANY _____			
		POLICY NUMBER _____ GROUP NUMBER _____	POLICY NUMBER _____ GROUP NUMBER _____			
		ADDRESS _____	ADDRESS _____			
		CITY _____ STATE _____ ZIP _____	CITY _____ STATE _____ ZIP _____			
		PHONE _____	PHONE _____			
		SUBSCRIBER NAME _____ DOB _____ SEX _____	SUBSCRIBER NAME _____ DOB _____ SEX _____			
<input type="radio"/>	MEDICAID/ OHP	POLICY NUMBER _____ STATE (if other than Oregon) _____				
		PREAUTHORIZATION NUMBER _____				
<input type="radio"/>	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. <b>SIGNATURE:</b> _____				

### RESPONSIBLE PARTY (GUARANTOR) NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Lab Medicine L471  
3181 SW Sam Jackson Park Rd  
Dillehunt Hall Rm. 3020  
Portland, OR 97239  
Phone: 503-494-7383  
Specialties Include:  
Hemostasis & Thrombosis 503-494-8445  
Flow Cytometry 503-494-2302  
Hematopathology 503-494-2302  
Occupational & Environmental Allergy 503-494-7743

Genetics Laboratories MP350  
2525 SW 3rd Avenue, Suite 350  
Portland, OR 97201-4950  
Phone: 503-494-5400  
Specialties Include:  
Biochemical Genetics 503-494-2404  
Cytogenetics 503-494-2790  
Molecular Diagnostics Center 503-494-7465

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

## OHSU Healthcare Laboratory Services

3181 S.W. Sam Jackson Park Rd., Portland OR 97239  
503-494-7383

### **BILLING POLICY FOR OHSU HOSPITALS AND CLINICS LABORATORIES**

OHSU Hospital Laboratories must receive complete information on the Laboratory Testing Requisition at the time of specimen receipt. Failure to provide this information will result in the ordering physician/clinic/laboratory 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 individual physician/clinic/laboratory 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 ordering physician/clinic/laboratory 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 ordering physician/clinic/laboratory will be billed. Physician NPI number and ICD9 code are required. Completed Medical Necessity ABN form and Medicare as Secondary Payor forms must accompany specimen when required.