



OHSU Hospitals and Clinics

LABORATORY TESTING REQUISITION

Main Mailing Address: 3181 S.W. Sam Jackson Park Rd., 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 YES NO <input type="checkbox"/> Yes <input type="checkbox"/> 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		UPIN/NPI (REQUIRED FOR MEDICARE)		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 NEXT PAGE) APPROPRIATE AREAS MUST BE COMPLETED OR REFERRING LABORATORY / PHYSICIAN WILL BE BILLED.
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<input type="radio"/>	REFERRING LABORATORY / PHYSICIAN (CLIENT)
<input type="radio"/>	PATIENT'S UNIVERSITY ACCOUNT FOR CYCLOSPORINE / FK506 TESTING

<input type="radio"/>	PATIENT	MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE
<input type="radio"/>	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 _____			

<input type="radio"/>	MEDICAID/ OHP	POLICY NUMBER _____ STATE (if other than Oregon) _____ PREAUTHORIZATION NUMBER _____
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<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. SIGNATURE: _____
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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 Hospitals and Clinics
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 UPIN or NPI 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 for OHSU patients ONLY: University Hospital will bill the current individual patient's account. The patient may obtain an account number by calling 503-494-8505.