OHSU Hospitals and Clinics
LABORATORY TESTING REQUISITION

Main Mailing Address: 3375 SW Terwilliger Blvd., Portland, OR 97239 Phone: 503-494-3040

(See next page for additional addresses and telephone numbers)

OHSU Casey Eye Institute

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
			☐ 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	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.

O REFERRING LABORATORY / PHYSICIAN (CLIENT)

O PATIENT'S UNIVERSITY ACCOUNT FOR CYCLOSPORINE / FK506 TESTING

O PATIENT

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE

O 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_____

O MEDICAID/ OHP

POLICY NUMBER __________ STATE (if other than Oregon) __________

PREAUTHORIZATION NUMBER __________

O 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 __________