**Physician Ordering Test (NPI Required) – Please Print**

Name: 
NPI: 
Address:

Street
City  State  Zip
Phone: (     )  Fax: (     )  Pager: (     )

**Patient Identification**

Last Name:  First:  MI:
Date of Birth:   /   /   Gender:  Male  Female
Medical Record # (if applicable):
Address:

Street
City  State  Zip

**Specimen Information**

Date of Biopsy:
Outside Case Number:
Other notes:

**Reason for Testing**: (include all pertinent diagnoses and ICD9 codes)

**Check all that apply:**

<table>
<thead>
<tr>
<th>Acid Fast Bacteria</th>
<th>Alcian Blue/Par</th>
<th>Actin, Muscle Specific</th>
<th>Actin, Smooth Muscle</th>
<th>ALK-1</th>
<th>Anti-CAT</th>
<th>Anti-CG</th>
<th>Anti-CG A</th>
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**Healthcare Professional Signature to Authorize Testing and Statement of Medical Necessity**

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

Signature:  Date:

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**Histology and IHC Test Request**

Phone: 314-362-7784  Fax: 314-360-4080

**Mail Samples to:**
Washington University Dept. of Pathology
Attn: AMP Core Lab
425 S. Euclid Avenue, Campus Box 8024
Saint Louis, MO  63110

**Date/Time Received:**
Accession Number:
Tech Initial:
Received:

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Signature:  Date:
PLEASE COMPLETE ALL INFORMATION BELOW. FAILURE TO DO SO MAY DELAY SAMPLE PROCESSING.

**PATIENT INFORMATION**

Patient Name (Last, First, MI): ____________________  Patient DOB (MM/DD/YY): ____________________

**INSURANCE & PRECERTIFICATION**

*NOTE: Precertification for all non-government insurance plans is required for genetic testing*

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Genomics and Pathology Services (GPS) can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact Jean Loehr, Patient Accounts Manager at 314-362-5641, e-mail: loehr@wustl.edu, for complete insurance filing information and the managed care contract list.

Precertification/Prior Authorization Number: ____________________

CPT Codes and Units Authorized: ____________________

**ATTACH COPY OF INSURANCE CARD (If not available, complete the following)**

Policyholder’s Name: ____________________  Last    First    M.I.

Policyholder’s Date of Birth: ____________________

Relationship to Patient: ____________________

Insurance Co. Name: ____________________

Insurance Co. Phone: ____________________

Plan Name: ____________________

ID #: ____________________

Group #: ____________________

**SELF-PAY / PATIENT FINANCIAL ASSISTANCE**

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact Jean Loehr, Patient Accounts Manager at 314-362-5641, e-mail: loehr@wustl.edu

**AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR ACCOUNT**

I authorize the disclosure of insurance benefit coverage and payment information to Washington University School of Medicine. I authorize Washington University School of Medicine to furnish any medical information requested on myself, or my covered dependents. I assign and authorize insurance payments to Washington University School of Medicine. I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if Washington University School of Medicine is not a participant with my health plan, and/or my health plan does not fully reimburse medical services due to lack of authorization or medical necessity.

Signature of Patient or Guardian: ____________________

Printed Name of Patient or Guardian: ____________________

Date: ____________________

**Reference Laboratories:** Complete the Section Below

**INSTITUTIONAL BILLING**

Institution Name: ____________________

Contact Name: ____________________

E-mail: ____________________

Billing Address: ____________________

City, State, Zip: ____________________

Tel: ____________________  Fax: ____________________