Indiana University Health

IU Health System Pathology Laboratories
350 W. 11th Street, Room 5013
Indianapolis, IN 46202-4108
317.491.6000 or 800.433.0740
Fax: 317.491.6001

1) Patient Legal Name (Last, First MI)		DOB	2) ( ) STAT	Date/Time of Collection
Patient Social Security #	Race	MR#/Alternate Pt ID		Phone Results To:
Patient Address		Phone		Fax Results To:
City, State, Zip		M F	4) **BILL PATIENT/INSURANCE COMPANY**	
3) Physicians Signature	Order Date	Print Physicians Name (F,MI,L)	ATTACH A COPY OF FACE SHEET AND INSURANCE CARD - ALL required (highlighted) fields must be complete to bill patient's insurance company. Specimen will be registered as patient self-pay and bill will be the responsibility of the patient if required information is not provided.	

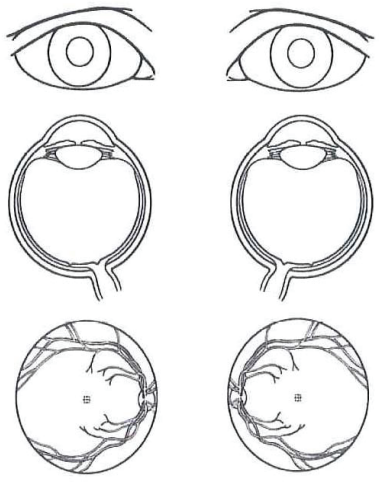
Client (Clinic/Physician) Information	Group Physicians	Primary Insurance
		Company Name:
		IU/Policy# Group #/Name:
		Insurance Co. Address:
Send Additional Report To:		City: State/Zip:
		Policy Holder Name:
		Relationship to Patient:

Notice: Medicare will only pay for tests that meet the Medicare definition of "Medical Necessity". Medicare may deny payment for a test that the physician believes is appropriate, such as a screening test. If a test is being ordered as a screen, be certain the patient has signed the Advanced Beneficiary Notice (ABN) located on back of this requisition.	5) ICD Diagnosis Codes (Enter ALL that apply)		*1*	*2*	*3*
	4	*5*	*6*	*7*	*8*

Ophthalmic Pathology

Please check one: ☐ **Inpatient** ☐ **Outpatient** ☐ **Ambulatory Surg Center**

Please provide ICD Diagnosis Codes in Section 5 above.



Clinical History: *Respond below and/or attach patient's most recent clinical history.*_____

_____

_____

_____

_____

Specimen Submitted: □ Wet Tissue □ Blocks □ Slides

Description_____

Date of Removal: _____ □ OD □ OS

Vision: OD _____ OS _____

Pressure: OD _____ OS _____

Referring Physician Information: *(If different from Ordering Physician/Client Information box at top)*
Ophthalmologist:_____Fax a final Report? Yes____No____
Address:_____Fax:_____City, State, Zip_____Telephone:_____

Please FAX this submission form and face sheet to the 317-491-6419 BEFORE sending all biopsies:
Attention: Ophthalmic Biopsy

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Patient Social Security #	Race	MR#/Alternate Pt ID		Phone Results To:
Patient Address		Phone		Fax Results To:
City, State, Zip		M F	4) **BILL FACILITY / CLIENT**	
3) Physicians Signature	Order Date	Print Physicians Name (F, MI, L)	( ) Split Bill: TC to Facility & PC to Insurance (Medicare, Medicaid) **Attention PFN**: do not register, send patient directly back to lab	
Client (Clinic/Physician) Information			Group Physicians	
Send Additional Report To:				

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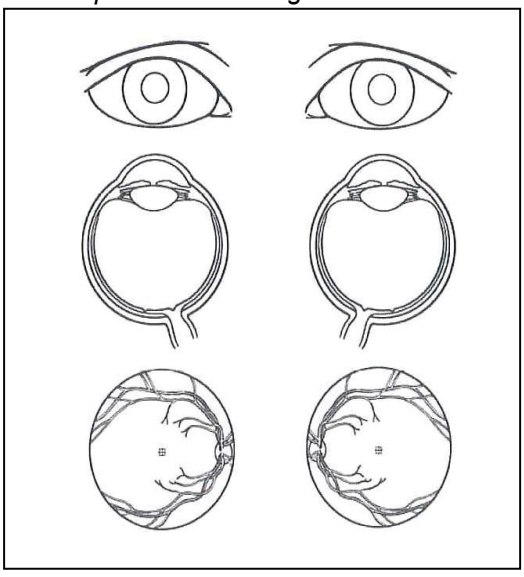

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