Wesley Medical Center
Department of Pathology
Requisition Instructions

Physician Information	Physician's full name, address & UPIN No. if not preprinted.		
Patient Information	a)	Patient's name	- (Print last name, first name, MI)
	b)	Social Security No.	- Required
	c)	Date of Birth	- Required
	d)	Sex	- Required
	e)	Phone No.	- Required
	f)	Marital Status	- Required for insurance
Responsible Party Information	a)	Responsible Name	- If different than patient, complete last, first, MI
	b)	Patient's Relationship	- Check appropriate box
	c)	Address, City	- Complete this part
Medical Necessity	a)	An ABN is required if tests have been ordered which Medicare is likely to deny. Complete ABN form with test name and reason test is likely to be denied. Ask patient to read and sign the ABN form.	
	b)	List narrative diagnosis and/or specific ICD-10 diagnosis code for the patient's current visit.	
	c)	Reference the ICD-10 code associated to each test or panel ordered in the appropriate ICD-10 column.	
	d)	Physician ordering the tests must sign the test order and date & time the order on the requisition.	
	e)	If Registering personnel note that test order information is missing, then they will contact the physician's office for clarification.	
Employer Information	Required for insurance billed patients		
Billing Information	Always attach copies of the insurance ID cards. Fill out both primary and secondary if present.		
	a)	Bill to	- Indicate who will be billed
	b)	Medicare No.	- Required for Medicare
	c)	Medicaid No.	- Required for Medicaid
	d)	Secondary Questionnaire	- Required for Medicare
	e)	Insurance Authorization No.	- If Applicable
	f)	Insurance Company Name	- Required for Insurance

		& Address	
	g)	Policy Name, No., Group Name & No.	- Required for Insurance
	h)	Insured Name & Relationship	- Required for Insurance
Specimen	a)	Stat and Call Results	- Complete if needed
Information	b)	Collected by	- Required (if done in office)
	c)	Date Drawn & Time Drawn	- Required (if done in office)
	d)	Indicate Sample Type	- Fasting or Random if known
	e)	24 Hour Urine Volume	- Submit measured volume if requesting 24 hour urine test
	f)	Time of Last Dose	- Indicate time of last medication dose if measuring drug level

Test and Panel Information

Check off the tests and/or panels requested. You may select either a panel or selected components in a panel. Single tests are in alphabetical order unless they are part of a panel. If you select (√) a panel you do not need to mark off (4) the individual components.

CPT Information

Those tests that do not have CPT codes listed can be performed by various methods and therefore it will be up to each facility to define the appropriate CPT code to use based on their equipment and methodology.