CASEY EYE INSTITUTE
515 SW CAMPUS DR
PORTLAND, OR 97239
ROOM 1140

OHSU Healthcare

OPHTHALMIC PATHOLOGY REQUISITION

PATIENT INFORMATION

PATIENT LAST NAME	FIRST	MI	SEX	BIRTH DATE	HOSPITAL STATUS
					☐ Inpatient ☐ Outpatient ☐ Non-Hospital
LABORATORY ACCESSION NO./ PATIENT IDENTIFICATION NO.		DATE COLLECTED		TIME COLLECTED	

RESPONSIBLE PARTY (GUARANTOR) NAME

SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX

ADDRESS	CITY	STATE	ZIP

TESTING INFORMATION

SPECIMEN SOURCE	****REQUIRED**ICD-10 DIAGNOSIS CODE(S) & ICD-10 DESCRIPTION**
TEST NAME(S)	

Results will be immediately available to the patient unless you mark the box below:
□ Do not release (I reasonably believe that an Information Blocking exception applies)

REFERRING LABORATORY/PHYSICIAN (CLIENT) INFORMATION

NAME	PHONE	FAX	
ADDRESS	CITY	STATE	ZIP

REQUESTING PHYSICIAN	**NPI** (REQUIRED FOR MEDICARE)	PHONE

ADDITIONAL REPORT TO	NAME			
	ADDRESS	CITY	STATE	ZIP

BILLING INFORMATION

SELECT ONE BILLING METHOD

Billing is done in accordance with the information provided below and OHSU Policy. Appropriate areas must be completed or referring laboratory/physician will be billed.

☐ **REFERRING LABORATORY / PHYSICIAN (CLIENT)**

☐ **PATIENT OR INSURANCE ****ATTACH COPY OF CARD******

PRIMARY			***SECONDARY***		
PREAUTHORIZATION NUMBER			PREAUTHORIZATION NUMBER		
INSURANCE COMPANY			INSURANCE COMPANY		
POLICY NUMBER	GROUP NUMBER		POLICY NUMBER GROUP NUMBER		
ADDRESS			ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
PHONE			PHONE		
SUBSCRIBER NAME	DOB	SEX	SUBSCRIBER NAME	DOB	SEX

CONTACT INFO

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