

**REQUISITION FORM**

**Surgical Pathology, Cytopathology, and Hematopathology**

**Additional Ancillary Studies Requested on Archived Case**

Archived Case > 30 days post sign-out

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

MRN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Case Number: \_\_\_\_\_

Date Ordered: \_\_\_\_\_

Pathologist: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Referring Physician Email: \_\_\_\_\_

Referring Physician Phone: \_\_\_\_\_

**Test Requested:** \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_

**BILLING INFORMATION**

**Bill to:**     Corporate Account: \_\_\_\_\_     Patient – please see below

**INSURANCE INFORMATION**

**\*\* If the patient has not been seen at NMH/NMG within the last 90 days, please complete the information below or provide a copy of the patient's insurance card.**

Insurance Provider: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder  
Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Please send completed form to NMH Surgical Pathology Send Out via:**

**Email: [SurgPathSendOut@nmh.org](mailto:SurgPathSendOut@nmh.org) or click**

**E-Fax: 312-694-8731**

**Questions regarding completing the form, call 312-926-7002.**