South Bend Medical Foundation
530 North Lafayette Boulevard
South Bend, IN 46601-1098

OUTPATIENT/CLINIC HOSPITAL HEMATOPATHOLOGY CONSULTATION REQUISITION

J.L. Simpson MD
Medical Director

Client Code: ( ) Name: ______________________
✓ Dr # Physician's Last Name, First Name
[ ] ______________________
[ ] ______________________
[ ] ______________________

Signature of Ordering Provider

____

(Signature must be dated, legible, and include first and last name)

Date______________________

Client Code: ____________ **Surgery Date:** ______________

Physician Performing Exam: ______________________

Attending Doctor(s): ______________________

Clinical Info: ______________

PLACE ACCESSION TAG HERE

Hospitals place patient label here

(If label not available, fill out below)

Med Rec No:______________________

Name: ______________________

SS#: _______-________-_________

Sex: ________ **Age:** ________ **DOB** ____/____/____

Outpatient/Clinic, please fill out Billing/Responsible Party info below

BILL to:

☐ PHYSICIAN / CLIENT ☐ PATIENT / RESP PARTY

BILL to: INSURANCE, MEDICAID, or MEDICARE

Provider Network:______________________

Insurance Company:______________________

____
Company Street Address

____
City State ZIP

Policy ID #: ______________ Group/Acct #: ______________

Policyholder Name: ______________________

Policyholder D.O.B: ______________________

RESPONSIBLE PARTY INFORMATION

____
Resp. Party's Last Name Legal First Name MI

____
Resp. Party's SS# Resp. Party's Phone #

____
Company Street Address

____
City State ZIP

Resp. Party's Employer:______________________

Patient's Relationship to Responsible Party: ☐ Self ☐ Child ☐ Spouse ☐ Other: ______________

MEDICAID Number: ______________________

Auth Code:______________ Eligibility Date: ______________ State: ______________

If pregnant, state EDD: ______________ If postpartum, state delivery date: ______________

MEDICARE Number:

Specimen/Clinical Information

Please submit most recent peripheral blood smear and CBC report

Check boxes below and completely fill in data required to indicate all materials submitted.

☐ Peripheral blood smear, Date: ______________ ☐ CBC Report, Date:______/______/______

☐ Bone marrow smears N. submitted: __________ ☐ Right No.:__________ ☐ Left No.:__________

☐ Bone marrow clot(s) N. submitted: __________ ☐ Right ☐ Left Time placed in fixative_____:_____

☐ Bone marrow biopsy(s) N. submitted: __________ ☐ Right ☐ Left Time placed in fixative_____:_____

☐ List any additional histopathology procedures requested by physician: ______________________

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For our locations and hours please visit our website @ www.sbmf.org or call us at
574-234-4176 and press 5
800-544-0925 and press 5

INSURANCE INFORMATION

Responsible Party Name (required if patient is a minor):

Responsible Party Address:

City | State | Zip

Responsible Party Phone

(   ) ______ - ____________

☐ Medicare # ________________________

☐ Medicaid # ________________________ EDD ____________ M/D/Y ____________

☐ Primary Insurance (Complete or attach copy of insurance card.)

INSURANCE COMPANY NAME:		
NETWORK:		
CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:
POLICY HOLDER NAME:		D.O. B.
RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent		
POLICY ID #:	GROUP #:	
EMPLOYER:	EFFECTIVE DATE:	

☐ Secondary Insurance (Complete or attach copy of insurance card front & back.)

INSURANCE COMPANY NAME:		
NETWORK:		
CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:
POLICY HOLDER NAME:		D.O. B.
RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent		
POLICY ID #:	GROUP #:	
EMPLOYER:	EFFECTIVE DATE:	

IMPORTANT

A WRITTEN ORDER AND AN APPROPRIATE DIAGNOSIS MUST ACCOMPANY EACH LABORATORY TEST. WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, ONLY TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT SHOULD BE ORDERED.

MICROBIOLOGY PROTOCOL

MICROBIOLOGY CULTURES MAY INCLUDE CHARGES FOR ONE PRIMARY SOURCE SMEAR, ONE PRIMARY CULTURE, ONE CHARGE PER ORGANISM REQUIRING IDENTIFICATION, AND ONE CHARGE PER SENSITIVITY PERFORMED. This is source specific. Refer to the fee schedule for further clarification, or call The Medical Foundation Client Services Department at (574) 236–7263 or (800) 950-7263

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

EVERY patient MUST read, sign, and date:

I request that payment of authorized Medicare or insurance benefits be made on my behalf to the South Bend Medical Foundation.

I authorize any holder of medical or other information about me to release to my designated insurance company, Centers for Medicare and Medicaid Services (CMS), and their agents, information to determine payable benefits for related services.

I agree that I am fully responsible for the payment of all the designated laboratory services South Bend Medical Foundation rendered to me or on my behalf. I accept responsibility for charges Medicaid does not cover when I am enrolled in a limited coverage Medicaid program.

I understand that additional testing may be performed based on my physician's request. I agree to be fully responsible for payment if my insurance plan does not cover the cost.

I also agree that if any insurance plan, except Medicaid, determines the tests requested to be medically unnecessary, and/or uncovered procedures, and denies payment to the South Bend Medical Foundation, I accept full responsibility for payment to South Bend Medical Foundation.

Patient Signature ________________________ Date ____________