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

Urology Test Requisition

J.L.Simpson MD
Medical Director

Client Code: ( ) **Name:** _____

✓	Dr #	Physician's Last Name, First Name	✓	Dr #	Physician's Last Name, First Name
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Signature of Ordering Provider

_____

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

Date_____-

PATIENT INFORMATION – Please PRINT

Name _____
Last First MI

SS#_____

DOB_____SEX _____
MO / DAY / YEAR

SPECIMEN COLLECTION

Date _____
MO / DAY / YEAR

Collector's Initials _____

Time: _____ ☐ AM ☐ PM
Fasting ☐ Yes ☐ No

BILLING

☐ PHYSICIAN / ACCOUNT
☐ PATIENT / INSURANCE
(SEE REVERSE SIDE)
IF NO BILLING INFORMATION IS PROVIDED, AND NO BOX IS CHECKED YOUR ACCOUNT WILL BE BILLED.

PRIORITY

☐ **Routine** ☐ **Phone** ☐ **STAT**
☐ **Fax #** _____

SEE REVERSE SIDE FOR ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

Copy to Physicians: Use complete name

Surgeon: _____
First Last

Attending: _____
First Last

Copy to: _____

DIAGNOSIS

Please provide diagnosis:

_____
_____
_____
_____
_____

CLINICAL INFORMATION:

PSA Last Result:_____
Date:_____
DRE/Clinical Stage:
☐ Non-palpable
☐ Palpable in ½ of one lobe or less
☐ Palpable in more than ½ of one lobe (but not both)
☐ Palpable bilaterally

PREVIOUS BIOPSY:

☐ Benign
☐ Suspicious
☐ HGPIN
☐ Adenocarcinoma

PREVIOUS THERAPY:

☐ Prostatectomy
☐ Radiation
☐ Cryotherapy
☐ Other:
_____

TISSUE BIOPSY

SPECIMEN:

Time Placed in Formalin: _____
# of Vials Submitted_____
☐ Bladder
☐ Vas Deferens
☐ Prostate BX – Single or Multiple
☐ Prostate – Saturation Biopsies

Left	Right
☐ Base	☐ Base
☐ Mid	☐ Mid
☐ Apex	☐ Apex
☐ Lat Base	☐ Lat Base
☐ Lat Mid	☐ Lat Mid
☐ Lat Apex	☐ Lat Apex

☐ All Sources
☐ Other_____
# of Vials Submitted_____
Pre Op Diagnosis _____
Post Op Diagnosis _____

CYTOLOGY / FISH TESTING

SPECIMEN TYPE:

☐ Voided Urine
☐ Cath. Urine
☐ Bladder Washings
☐ Post Cystoscopy Void
☐ Renal Washings ☐ Rt. ☐ Lt.
☐ Ureteral Washings ☐ Rt. ☐ Lt.
☐ Ileal Conduit
☐ Other _____

PROCEDURE:

☐ UroVysion™ FISH
☐ Cytology and UroVysion™ FISH
☐ Cytology with Reflex FISH (if cytology is Atypical/Suspicious)
☐ Cytology with Reflex FISH (if cytology is Negative)
☐ Cytology Only
☐ Other_____

REPORTING OPTIONS:

☐ Combined Cytology/UroVysion™
☐ Individual Cytology/UroVysion™ Report

Required Medical Necessity for UroVysion™ Testing: (Please check all that apply)

☐ Recurrent Bladder Cancer ☐ Hematuria ☐ Other_____

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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