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REQUEST FOR ADDITIONAL TESTING OF TISSUE PATHOLOGY SPECIMEN

Please send the tissue specimen on Patient/DOB_____

and IPA case number _____ for _____

testing of the patient's tumor. I attest that the testing is considered standard of care and is recommended for purposes of planning therapeutic intervention.

Authorizing signature _____

Authorizing signature (PLEASE PRINT) _____

Date _____

Contact person at facility (PLEASE PRINT) _____

Phone number_____

Fax number_____

Location of patient at time of request (**must** choose one of the 3 options below as patient's location determines insurance payment rules)

*_____ **Inpatient hospital** - Patient is a hospital inpatient (receiving services from hospital staff on hospital grounds, occupying an overnight bed at the facility) at the time of order.

*_____ **Outpatient hospital** - Patient is a hospital outpatient (receiving services form hospital staff on hospital grounds, but not an overnight stay) at the time of order.

*_____ **Non-hospital patient** - Patient is not a hospital patient, either inpatient or outpatient, at the time of order. Often, these patients are seen in a clinic setting near the grounds of a hospital but are not registered as patient of a hospital facility.

****Please attach patient's current insurance & demographics info and fax with this completed request form to 515.241.8867****

For IPA Office Use Only:

___IPS report printed

___Slides looked at by: JC HD JE Hall BH BK JM JMc JPM Scott JS BS

___test on block _____

___computer

___logged

___charged (include copy of this form and insurance)