METHODIST HOSPITAL | METHODIST WOMEN'S HOSPITAL

The Pathology Center
P.O. Box 24424
Omaha, NE 68124-0424
(402) 354-4541
(888) 432-8980

707 N 190th Plaza
Omaha, NE 68022
(402) 815-1174
(888) 432-8980

☐ Gretna PC
☐ Hawthorne PC
☐ Healthwest PC
☐ Indian Hills PC/Women's Center IH
☐ Louisville PC
☐ Malvern PC
☐ MCC
☐ MH (Dept.) _____
☐ WH (Dept.) _____

☐ Millard PC
☐ Northwest PC
☐ Papillion PC
☐ Red Oak PC
☐ Regency PC
☐ MCHC
☐ South PC
☐ Valley PC

☐ WDMP
☐ Women's MOB
☐ WR Cardio PC
☐ Cass Street PC
☐ Diabetes and Endo PC
☐ Elkhorn PC
☐ Other_____

Dear Doctor:

Described below is a verbal order that you recently communicated to us. Federal regulations require that we must perform test only at your written or electronic request.

***Please review our documentation of your telephone request for correctness, provide ICD-10CM or diagnosis information as required by federal regulation**, sign in the indicated area and fax this document to us within 24 hours.*

Please remember when ordering laboratory tests that are billed to Medicare/Medicaid, or other federally funded programs that only tests that are medically necessary for the diagnosis or treatment of the patient should be ordered. Medicare does not pay for screening tests except for certain, specifically approved procedures and may not pay for non-FDA approved tests or those tests considered experimental.

FOR LAB USE ONLY

Date_____

Time_____

Fin#/Visit ID_____

Rec'd by_____

Patient Legal Name_____

Patient DOB_____

Date of Collection_____ Time_____ Requested By_____

Physician_____

FAX#_____PHONE#_____

Test Requested _____ _____

_____

☐ **ACTIVATE FUTURE ORDER / CO-SIGN REQUIRED**

****CHECK BOX ONLY IF ORDERS ARE PLACED IN CERNER SYSTEM OR ORDERS REQUIRE ELECTRONIC ORDERING PHYSICIAN SIGNATURE****

ICD-10 Code/Diagnosis _____ _____

_____ _____

A Valid ICD-10 code or complete diagnosis is required to bill insurance. **

Physician/Authorized Signature _____ Date _____

****SIGNATURE REQUIRED ONLY IF ORDERING PROVIDER IS OUTSIDE OF NEBRASKA METHODIST CPOE SYSTEMS*****

Please fax completed form to: (402)354-8806

FOR LAB USE ONLY

Test(s) performed_____

Accession # _____ _____

Ordered ☐ Yes ☐ No ☐ Merged By_____ Date_____

☐ Ordered CO-SIGN REQUIRED ☐ Faxed for Signature Date_____

Follow Up _____

STORAGE TRACKING_____