UAMS
University of Arkansas for Medical Sciences

Address Package:
Dr. _____:
4301 West Markham #517
Little Rock, AR 72205
Phone: 501-686-5170

REQUISITION FORM

PATIENT DEMOGRAPHICS

Full Legal Name:		DOB:	Age:
SSN:	Race:	Sex: ☐ Male ☐ Female	Phone #:
Current address:			
City:	State:	ZIP Code:	
MRN:			

Insurance & Billing Information (Card Attachment Required)

Please attach signed primary care physician referrals and prior authorizations if it is required by the patient's insurance company.

Is the patient a minor?: ☐ yes ☐ no (If yes, please provide Guarantor information)		
Guarantor legal name:	Guarantor DOB:	Guarantor SSN:
Bill to: ☐ Medicaid ☐ Medicare ☐ Other Insurance ☐ Client/Institution (please attach billing information)		
Patient Status: ☐ Inpatient ☐ Outpatient ☐ Office		Hospital Discharge Date:
Primary: ☐ Self ☐ Spouse ☐ Child		
Subscriber full legal name:		DOB (if subscriber is not patient):
Beneficiary / Member #:		Group #:
Claims Address:		City:
State:	Zip:	Claims Phone #:
Secondary Insurance: ☐ No ☐ Yes (If yes, please attach card)		
DIAGNOSIS CODE (REQUIRED) ICD-10 CODES:	**1.**	**2.**

ORDERING PHYSICIAN CONTACT

Name of Institution /Clinic:	
Physician Name:	
Physician NPI:	Phone:
Physician Email:	Fax Report to:

Specimen A:

Specimen Source:	Procedure Preformed:
Collection Date:	Accession/Case #:

Check if Appropriate: ☐ Punch ☐ Punch Excision ☐ Shave ☐ Shave, Excision ☐ Curettings ☐ Excision ☐ Wide Excision

# of Blocks:	# of Slides:	☐ Stained Slides ☐ Unstained Slides
Clinical History:		

Specimen B:

Specimen Source:	Procedure Preformed:
Collection Date:	Accession/Case #:

Check if Appropriate: ☐ Punch ☐ Punch Excision ☐ Shave ☐ Shave Excision ☐ Curettings ☐ Excision ☐ Wide Excision

# of Blocks:	# of Slides:	☐ Stained Slides ☐ Unstained Slides
Clinical History:		

***** UAMS will bill client and/or will not process the case IF updated insurance is not provided, IF Primary Care Physician Referrals or Prior Authorizations are not provided, and/or IF charges are denied due to current insurance. For Medicare patients classified as a hospital inpatient or outpatient on date of service, technical charges will be billed to referring client. *****

Physician Signature/Date: _____