Requisition/Pre-Authorization Form

Date:_____

Ordering Physician Name:_____Client Code:_____

Office Address:_____

Phone #:_____ Fax #:_____

Regional Medical Laboratory has received a request for additional testing on a specimen previously tested at RML on the following patient. Please verify and update the following information.

Patient name:_____

Date of Birth:_____ Date of Service:_____

Test Requested:_____

Patient Insurance on record at RML _____

If insurance listed above is incorrect, please provide correct insurance information:

Insurance Name: _____

Policy Number:_____ Group Number:_____

Inpatient: Yes ☐ No ☐ Medicare Patient: Yes ☐ No ☐

☐ **Insurance pre-authorization required - Doctors office must contact the patient insurance and provide the pre-authorization number obtained _____**

Many insurances are requiring pre-authorizations for genetic and molecular testing. If noted above the patient's insurance company is requiring the ordering physician to obtain a pre-authorization before additional testing can be performed. Please obtain the pre-authorization as Regional Medical Laboratory is unable to obtain the pre-authorizations from insurance companies. If no pre-authorization is obtained, Regional Medical Laboratory will bill the provider any unpaid charges. By signing this request, you will take responsibility for any additional charges not paid for by the patient's insurance and will release Regional Medical Laboratory from such responsibility.

Requesting clinician's signature (required):_____

Date:_____

If you have any questions, please call to speak with an RML Technical Secretary at 918-744-2553.
Fax to 918-744-3327 in order for your request to be expedited.