



URMC  
LABS

# ONE TIME AUTHORIZATION FOR RESTRICTED or OFF FORMULARY-TESTS

**Directions:** Please complete and sign this form. Fax (585) 475-0862 or email to: [laboratorydiagnosticscommittee@urmc.rochester.edu](mailto:laboratorydiagnosticscommittee@urmc.rochester.edu)

For Information and Results Call  
Pathology and Lab Medicine  
Client Services **(585) 350-2600** OPT 3

**\*\*\*ALL FIELDS ON THIS FORM MUST BE COMPLETED IN ORDER TO PROCESS FOR REVIEW\*\*\***

**REQUIRED (PRINT OR PATIENT LABEL)**

Name (Last, First, MI)	
Date of Birth	Sex: (circle) M F
<b>Indicate primary (1) and secondary (2) insurance</b>	
<input type="checkbox"/> Blue Cross/Shield	<input type="checkbox"/> Child Health Plus <input type="checkbox"/> MVP <input type="checkbox"/> Other
<input type="checkbox"/> Blue Choice	<input type="checkbox"/> Medicaid <input type="checkbox"/> MVPG
<input type="checkbox"/> Medicare Blue Choice	<input type="checkbox"/> Medicare <input type="checkbox"/> Aetna

Doctor: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Phone: \_\_\_\_\_

Please provide patient diagnosis and a detailed explanation as to how results of requested test(s) will influence your clinical management and care of this patient. If the patient is a hospital in-patient, please explain how these results will influence your treatment plan during current admission.

**Test(s) requested :**

**Diagnosis/Explanation Required:**

I \_\_\_\_\_, M.D. am the Physician of record or a Consulting Physician caring for the patient identified above. I am requesting a laboratory assay that may not be provided by the URMCLaboratories of Strong Memorial Hospital/Highland Hospital and may require shipment of sample to an outside reference laboratory to perform this assay. I understand that the time required to process, ship, and to receive results from an outside reference laboratory generally requires a minimum of five (5) business days, and that for certain assays, results may not be available for several weeks.

***In making this request I certify that the results of the laboratory assay(s) that I have requested above are medically necessitated and are likely to alter my diagnosis and/or my treatment plan for this patient.***

Signed \_\_\_\_\_, M.D.  
 (Physician)  
 Print Name \_\_\_\_\_, M.D.  
 Pager # (required) \_\_\_\_\_

Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-9 code(s) or a descriptive diagnosis must be included on each patient for each test ordered. It is critical that the diagnosis provided to lab is consistent with those recorded in the patient medical record on the date of service.

### AREAS BELOW FOR LAB USE ONLY

<input type="checkbox"/> Restricted <input type="checkbox"/> Off-Formulary	Performing Lab:	Approved by LDC: Y or N
NYS approved: Y or N	Specimen Requirements:	Add to Formulary Y or N Date:
CPT Codes:	TAT	Price: