LUMEA, Inc.
2889 W Ashton Boulevard STE 300
Lehi, UT 84043
844-960-3658
CLIA 46D2103543
FedEx Pickup: 1-800-463-3339

LABORATORY USE	
Accession #	
Date/Time Received	# of Specimens

BLADDER BIOPSY REQUISITION FORM

* = Required

PATIENT AND BILLING INFORMATION

*Patient Name	*Gender ☐ Male ☐ Female	*Birthdate

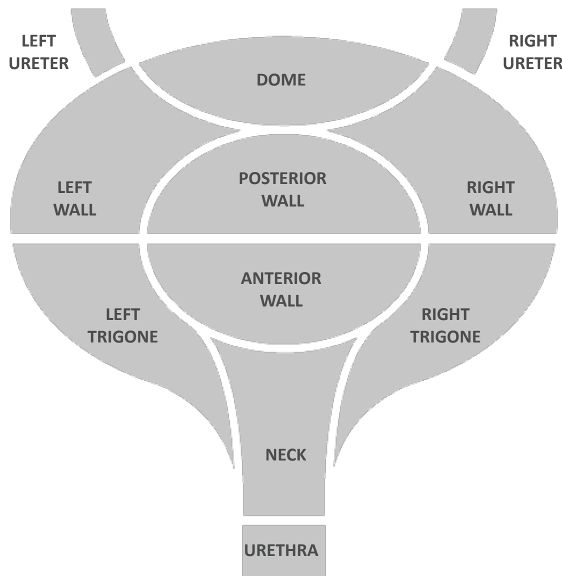
A COPY OF THE PATIENT'S DEMOGRAPHIC AND INSURANCE INFORMATION MUST BE SUBMITTED WITH THE SPECIMENS AND THIS REQUISITION FORM

ENCOUNTER INFORMATION

*Physician	*Date of Biopsy Procedure
*Clinic	*Medical Assistant

TRADITIONAL SPECIMEN INFORMATION

*Mark an "X" over each site from which specimens are being submitted.
If multiple biopsies are removed, write the amount on the corresponding site.



*ICD-10 Code

- ☐ R9341 Ultrasound Nodules
- ☐ Z85.51 History of Cancer (Personal)
- ☐ R35.0 Frequency
- ☐ R93.41 Abnormal Radiology
- ☐ R31.9 Hematuria
- ☐ R30.0 Dysuria
- ☐ N32.0 Obstruction
- ☐ N32.9 Bladder Disorder, Unspecified
- ☐ D49.5 Neoplasm of Unspecified Behavior of Other Genitourinary Organs
- ☐ Other: ____________

DEFAULT RULES OUT

- ☐ Malignancy
- ☐ Interstitial cystitis
- ☐ Other: ____________

PHYSICIAN AUTHORIZATION

I hereby authorize testing and confirm: 1) that informed consent has been obtained, if required by state law; 2) that this test is medically necessary and the results will be used in the medical manage-ment and treatment decisions for the patient; 3) that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to histopathology laboratory service providers, including LUMEA, Inc., and to ancillary healthcare services providers as necessary. I authorize LUMEA and other designated healthcare service providers to release the information on this form, and other information provided by me, necessary to process a claim for this service. I hereby attest that the person listed in the Physician space above is authorized by law in the relevant jurisdiction to order the test(s) requested herein.

*Signature of Referring Provider (DO, MD, NP, PA)	*Date

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