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

SURGICAL PATHOLOGY REQUISITION FORM

* = Required

PATIENT AND BILLING INFORMATION

*Patient Name	*Gender ☐ Male ☐ Female	*Birthdate
Symptoms/History		
*Differential Dx/ICD-10		

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 Procedure
*Clinic	*Medical Assistant

SPECIMEN INFORMATION

*Procedure Type

Tissue Type, Site(s)	Time Tissue Removed	Time Placed in Fixative	Other Specimen Details
1.			
2.			
3.			
4.			
5.			

Special Requests for Laboratory

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 treat-ment 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