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# FAX

Department: Pathology  
Fax: (402)354-4535

To:		From:	
FAX:		Phone:	
Pages:	(including cover sheet)	Date:	
RE:			

**To more effectively and efficiently process Pathology requisitions, the following information is REQUIRED: FAILURE TO DO SO WILL DELAY PROCESSING.**

- **PATIENT INFORMATION:** Please complete ALL patient information on the left side of the attached pathology requisition form, including **DIAGNOSIS CODE**.
- **HEALTH INSURANCE INFORMATION:** Attach a legible copy of the patient's health insurance information. If policy holder is not the patient, include the name of policy holder and their date of birth.
- **PRE-AUTHORIZATION:** All tests may require authorization. The tests with the asterisk require pre-authorization. **EXAMPLES:**

**Medicare patient - Does not require pre-authorization**  
**United Healthcare Plan - Does not require pre-authorization.**  
**Simply checking the "NOT REQUIRED" box is insufficient.**

**Questions, please contact ROZ, HELEN, or ANNE at (402)354-4550. Thank you.**

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### Confidentiality Notice

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