Health Care Request for New Laboratory Test - Undefined

New laboratory requests are selected for inclusion by the Laboratory Utilization Committee to the test catalog based upon scientific validity regarding the role in diagnosis or disease management, availability of similar tests already on the test catalog, ease of collection and specimen processing and cost.

All requests require review and authorization by the MUHC Laboratory Utilization Committee prior to specimen submission. Please allow for 4 weeks of review process. For additional question, please contact the Call Center at (573)884-4522.

Email this completed form to General - LUWC - Ogrp <c080f3df.groups.umsystem.edu@amer.teams.ms>

All yellow fields are Mandatory – incomplete forms will delay the review.	
Test Requestor's Information	
Today's Date:	
Requestors Name:	
Supervising Attending Physician, if different from Requestor:	
Specialty/Clinic	
Email	
Contact Phone Number	
Do you have a current Conflict of Interest disclosure on file in eCompliance?	Select
Test Information	
Requested Test Name	
Testing Laboratory Name	
Testing Laboratory Contact Information	
Is this a Test for a Research Study or Clinical Trial?	Select
Is this a Genetic Test?	Select
Is this an FDA approved Test?	Select
What have you been using in the absence of this test	
Which related tests are currently in the MUHC or approved reference lab test catalog? Please see https://muhealth.testcatalog.org/show/RLTestRef for a list of currently approved reference labs and tests.	
What is/are the advantage(s) of this test versus comparable product(s) currently on the UMHC test catalog?	
Which test(s), if any, can this replace?	
What are the proposed criteria for appropriate use of this lab test at UMHC (indications, place in diagnosis or management, special precautions, etc.)?	
Test Billing Information	
CPT Code	
All Outpatients: Institutional billing vs third party Billing?	Select
Third Party Billing: Will prior authorization and benefit analysis be initiated by the provider or patient?	Select
Test Request	
Is this request for a particular patient?	Select
**If yes please, provide the following:*	
Patient Name	

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Patient Med Record #	
Is this an inpatient?	
Specimen other than blood or urine? If so specify:	
Volume and Handling	
Approximately how many patients will be tested per year?	
Does the requisition form require completion of clinical information?	
Is special processing (esoteric specimen containers, special preservatives, etc.) required? If so, please Specify	
Please provide additional information as needed	
Please furnish published literature which demonstrates in controlled, comparative studies a superior diagnostic or therapeutic advantage of this test. If such studies are unavailable, please furnish a copy of the literature which has convinced you to request this test.	