COCKERELL DERMATOPATHOLOGY

C O N S U L T I N G   S E R V I C E S

Thank you for your consultation regarding the below referenced patient. It is our policy to bill the physician unless notified to bill the patient directly or the patient's insurance. **NOTE: MEDICAID considers this a non-covered item. HMOs require pre-authorization prior to submission of slides.** If the patient or patient's insurance is to be billed for these services, please complete the patient billing information listed below. Please mail this form along with a copy of the insurance card, slides and blocks to our practice as soon as possible, to the attention of Consulting Services.

REQUESTING PHYSICIAN:

NAME ______________________ PHONE (   ) ______________

ADDRESS STREET/SUITE # ______ CITY ______ ST ______ ZIP ______ FAX (   ) ______________

NPI # ______________________ E-MAIL ______________________

PATIENT INFORMATION:

PATIENT LAST ______ FIRST ______ MI ______ PHONE (   ) ______________

ADDRESS STREET/APT # ______ CITY ______ ST ______ ZIP ______

DOB ___/___/___ SEX ______ RACE ______

BILLING METHOD: ❍ PHYSICIAN ❍ PATIENT ❍ INSURANCE ❍ MEDICARE

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED: ❍ SELF ❍ SPOUSE ❍ DEPENDENT

INSURED NAME ______________________

INSURANCE NAME ______________________ INSURANCE PHONE ______________

INSURANCE ADDRESS ______ CITY ______ ST ______ ZIP ______

EMPLOYER NAME ______________________

SUBSCRIBER DOB ______ MEMBER ID # ______ GROUP/CONTRACT # ______

MEDICARE # ______________________

CLINICAL / DIAGNOSTIC COMMENTS: # OF SLIDES: __________ # OF BLOCKS: __________

LAB USE ONLY:

88321______	88325______	88312______	88313______	88342______
(B-CELL)	83898______	83891______	83894______	83912______
(T-CELL)	83898______	83891______	83894______	83912______

ICD-9___________ ICD-9___________ ICD-9___________

REPORT DATE: ______________________

SLIDE #: ______________________

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INCLUDE WHITE AND YELLOW COPIES WITH SLIDES

CS-01 RV 9/13