

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.

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, 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_____ : REPORT DATE: _____
(B-CELL) 83898_____ 83891_____ 83894_____ 83912_____ :
(T-CELL) 83898_____ 83891_____ 83894_____ 83912_____ :
ICD-9_____ ICD-9_____ ICD-9_____ : SLIDE #: _____