

# 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.

**Medicaid considers consultaions as a non-covered service. Most HMOs require pre-authorization prior to submission of case for consultation.**

If the patient or patient's insurance is to be billed for these services, complete the patient billing information listed below. Please send this requisition along with a copy of the insurance card, slides and blocks to our practice, to the attention of Consulting Services. This requisition is type fillable or can be completed by hand.

**TIME SAVING TIPS:** Download this requisition to your computer. Type in Requesting Physician information and save. This will save time on submitting future consultation cases. Use the tab key to quickly advance to the next field.

## 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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ GENDER \_\_\_\_\_ 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 # \_\_\_\_\_

# OF SLIDES: \_\_\_\_\_ # OF BLOCKS: \_\_\_\_\_

**DIAGNOSTIC COMMENTS OR ADDITIONAL NOTE:**

LAB USE ONLY:  
88321\_\_\_\_\_ 88325\_\_\_\_\_ 88312\_\_\_\_\_ 88313\_\_\_\_\_ 88342\_\_\_\_\_ REPORT DATE: \_\_\_\_\_  
88341\_\_\_\_\_ 88365\_\_\_\_\_ 88364\_\_\_\_\_  
ICD-10\_\_\_\_\_ ICD-10\_\_\_\_\_ ICD-10\_\_\_\_\_ SLIDE #: \_\_\_\_\_