COCKERELL DERMATOLOGY

CONSULTATION SERVICES

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 #: _____

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