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 / / _____ 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 # _____

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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