We have received your request for consultation on the above case. If your institution is willing to pay, please

- fill in ALL of the requested information on the second sheet (marked with an "x")
- SIGN it and
- fax it back to the number listed above (617) 726-7474.
- Going forward - please state on your cover letter who will be responsible for the consultation fee

We must receive this information before accessioning your case. Your immediate attention is required.
PATHOLOGY CONSULT REQUEST FORM

Please provide the information below. If this information is not completed, it may lead to the case being returned without review.

REQUIRED INFORMATION TO BE INCLUDED IN THIS PACKAGE:

- Patient Demographics
- Patient Insurance Information
- Insurance authorization (if applicable)
- Pathology material
- Original (and/or your institution’s) pathology report
- Signed billing agreement – (see below)

NAME & NPI NUMBER OF ORDERING/REFERRING PHYSICIAN/PATHOLOGIST:

Referring MD full name ___________________________ NPI # ___________________________
Address: ______________________________________ Telephone # ___________________________
Fax # _______________________________________

PATHOLOGY ACCESSION/LABEL NUMBER: ___________________ PATIENT NAME: ___________________

___ Number of stained slides

___ Number of unstained slides DOB: _____________________________
___ Number of blocks

BILL OUR INSTITUTION. Yes, I accept your billing policy and will make payment to Massachusetts General
Pathology Associates after performance of services and receipt of bill.

COMPLETE ALL REQUESTED INFORMATION; SIGN, PRINT NAME, AND DATE BELOW.

Office or Institution Name: ________________________________
Billing Contact Name: ________________________________
Billing Contact Email Address: ________________________________
Street Address: ________________________________
City, State, Zip: ________________________________
Telephone: ________________________________
PO/Referral # (if applicable): ________________________________

OR

BILL THE PATIENT’S INSURANCE. Detailed patient demographics are enclosed. PLEASE NOTE: WE DO NOT
ACCEPT OUT OF STATE MEDICAID WITH THE EXCEPTION OF THE NEW ENGLAND STATES. (IF PAYMENT IS
DENIED BY THE PATIENT’S INSURANCE, YOUR INSTITUTION WILL BE RESPONSIBLE FOR APPLICABLE
CHARGES.)

Signature: _____________________________ Date: _____________________________
Print name: _____________________________
## Massachusetts General Hospital Fee Schedule for Consultation Cases

<table>
<thead>
<tr>
<th>Name</th>
<th>Rate</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>WRN CPT 88321</td>
<td>$340</td>
<td>Consultation and report on referred slides prepared elsewhere</td>
</tr>
<tr>
<td>WRN CPT 88323</td>
<td>$350</td>
<td>Consultation and report on referred material requiring preparation of slides</td>
</tr>
<tr>
<td>WRN CPT 88342</td>
<td>$215</td>
<td>Immunoperoxidase Stain</td>
</tr>
<tr>
<td>WRN CPT 88342 Reading Only</td>
<td>$158</td>
<td>Immunoperoxidase Stain (reading only)</td>
</tr>
<tr>
<td>WRN CPT 88341</td>
<td>$159</td>
<td>Immunoperoxidase Stain (each additional)</td>
</tr>
<tr>
<td>WRN CPT 88341 Reading Only</td>
<td>$99</td>
<td>Immunoperoxidase Stain (each additional, reading only)</td>
</tr>
</tbody>
</table>

Revised 3/25/2022 – Effective 04/01/2022