Massachusetts General Hospital
Department of Pathology Consult Service
Tel: 617-726-9544 Fax: 617-726-7474

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

x _____ **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 marked with an x; sign and date below.***

x	**Office or Institution Name:**	
x	**ATTN:**	
x	**Street Address #1**	
x	**Street Address #2**	
x	**City, State, Zip Code:**	
x	**Telephone Number:**	
x	**Fax Number:**	
X	**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

_____ _____
Print Name Date