THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

PATHOLOGY CONSULTATION
International Patients Billing Information

INTERNATIONAL PATIENT DEMOGRAPHIC INFORMATION
BILLING INFORMATION

(1) Bill Patient's home address as above (patient may be contacted)
NOTE: INCOMPLETE PATIENT OR BILLING INFORMAITON WILL DELAY PROCESSING OF YOUR REQUEST

NAME:		
ADDRESS:		
CITY:	STATE/COUNTRY:	ZIP/COUNTRY CODE:
PHONE:	FAX:	EMAIL:
DOB:	SEX:	

(2) Bill Contributor

NAME:		
ADDRESS:		
CITY:	STATE/COUNTRY:	ZIP/COUNTRY CODE:
COUNTRY:		
PHONE:	FAX:	EMAIL:
UPIN/NPI:		

Send bill to the attention of:
Print Name:
Signature:

(3) Bill Credit Card *(American Express, Visa, MasterCard, and Discover accepted)*

TYPE:	EXPIRATION DATE:
CARD NUMBER:	
CARD HOLDER'S NAME:	Name should be entered as it appears on card *I authorize MD Anderson Cancer Center to charge the above credit card for this consultation*
CARD HOLDER'S SIGNATURE:	