

PATHOLOGY CONSULTATION Domestic Patients Billing Information

*Note: patient and/or insurance provider will be contacted. We are unable to process out of state Medicaid requests
Incomplete patient or billing information will delay processing of your request.*

1. Bill contributor

Name:		
Mailing Address:		
City:	Country:	Zip Code:
Phone:	Fax:	E-Mail:
Alt Phone:		

Send the bill to the attention of: _____

Authorized Signature: _____

Print name: _____

Clinical Information: Diagnosis: _____ ICD-9 Code: _____

2. Bill patient's primary insurance. Medicare patients, please list secondary insurance if applicable (attach faxesheet)

Any insurance updates must be received within 40 days of date of service to rebill the account

Name of Patient:		
Marital Status:		
Health Plan:		Phone:
Address:		Name of Subscriber:
Address:		
DOB of Subscriber		Relationship to Patient
Policy Number:	Group Number:	Effective Date:
Referring Physician UPIN/NPI:	Fax:	E-Mail:

3. Bill patient's secondary insurance.

Health Plan:		Phone:
Address:		Name of Subscriber:
Address of Subscriber:		
DOB of Subscriber		Relationship to Patient
Policy Number:	Group Number:	Effective Date:
Referring Physician UPIN/NPI:	Fax:	E-Mail:

4. Bill credit card *American Express, Visa, MasterCard, and Discover Card accepted.*

Type:	Expiration Date:
Number:	
Card Holder's Name:	Card Holder's Signature:

5. Bill patient's home address (patient will be contacted)

I authorize MDACC to charge the above credit card for this consultation.

Signature: _____