

PATHOLOGY CONSULTATION International Patients Billing Information

Billing information *Incomplete patient or billing information will delay processing of your request.*

1. Bill patient's home address *Note: patient and/or insurance provider may be contacted.*

Patients Name:		
(Last)	(First)	(MI)
Patient's Mailing Address:		D.O.B.:
City:	Country:	Zip Code:

2. Bill contributor

Name:		
(Last)	(First)	(MI)
Mailing Address:		
City:	Country:	Zip Code:
Phone:	Fax:	*E-Mail:
UPIN/NPI:		

Send the bill to the attention of: _____

Signed: _____

Print name: _____

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

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

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

Signature: _____