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

PATHOLOGY CONSULTATION
Patient Demographic and Billing Information

PATIENT DEMOGRAPHIC

NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
COUNTRY:		
PHONE:	FAX:	EMAIL:
SSN:	DOB:	GENDER: Male ☐ Female ☐
MARITAL STATUS: Married ☐ Single ☐		

BILL CONTRIBUTOR

Please select one of the following and provide pertinent information below:

- ☐ Bill Patient's home address as above (patient may be contacted)
- ☐ Bill patient's primary insurance (patient and/or insurance provider may be Contacted)
- ☐ Bill submitting facility

COMPANY:	PHONE:	
ADDRESS:	NAME OF INSURED:	
ADDRESS OF INSURED:		
CITY:	STATE:	ZIP:
POLICY #:	GROUP #:	EFFECTIVE DATE:
REFERRING PHYSICIAN UPIN:	FAX:	EMAIL:

Financial Obligations

Below are the services that we provide, along with the estimated minimum cost. **IMPORTANT** - Reviews cannot be processed without credit card payment information. By providing this information, you are authorizing Pathology to post charges to your credit card (s) without having to provide you with advanced notification of charges being made.

Please note that any incomplete patient or billing information will delay processing of your request.

Service

Reading of pathology materials by a pathologist with completed and typed report.

Estimated Cost

Minimum $525 and as high as $4000 + as it relates to materials provided for review. It is not possible to know the actual total cost before finalizing the review.

BILL CREDIT CARD

TYPE: PLEASE SELECT	CARD NUMBER:	EXPIRATION DATE:
CVV:	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:		

ALTERNATE CREDIT CARD

TYPE: PLEASE SELECT	CARD NUMBER:	EXPIRATION DATE:
CVV:	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:		