CHECKLIST FOR PATHOLOGY CONSULTATION

Below is a checklist to help you submit the appropriate material(s) and document(s) for pathology consultation:

Item	United States	International
Pathology Consultation Demographic and Billing Form	✓	✓
Surgical Pathology Report This report must have the same identifying number as the glass slides and/or paraffin blocks. This is the only way the pathologist can verify that the tissue is yours	✓	✓
Paraffin blocks and/or unstained slides or other materials. Any unstained sections should be on Plus(+) or charged slides suitable for possible immunohistochemistry	✓	✓
Return of pathology materials will be by US Postal Service unless a FedEx or UPS account number is provided.	✓	✓
Letter to US Customs	N/A	✓

Please fill out all highlighted fields to avoid any delays in processing. For the Billing Section on page 2, attach the insurance card if available. If the insurance card is not available please fill in the fields for that section.

Washington University Physicians®

PATHOLOGY: Consultation Request

SEND PACKAGES(S) TO:

FED EX, UPS, US MAIL:
Dr. Fouad Boulos
Washington University School of Medicine
Department of Pathology & Immunology
Clinical Support Office
425 S. Euclid Avenue, MSC: 8024-14-04
Saint Louis, MO 63110
Phone: 314-747-1100 | Fax: 314-362-4080

COURIER:
Dr. Fouad Boulos
Washington University School of Medicine
Department of Pathology & Immunology
Clinical Support Office
509 S. Euclid, West Bldg, 4th floor
Saint Louis, MO 63110
Phone: 314-747-1100 | Fax: 314-362-4080

Office use only

Bar code

Physician/Service:

REQUEST CANNOT BE PROCESSED WITHOUT PATHOLOGY REPORT AND COMPLETE REGISTRATION INFORMATION

PATIENT INFORMATION - COMPLETE ALL FIELDS

Last Name:		First Name:		MI:
SSN:	Age: DOB (mm/dd/yyyy):		Gender: ☐ Male ☐ Female	
Address:		City:	State:	Zip:
Phone:				

BILLING INFORMATION - COMPLETE ALL FIELDS

PLEASE CHECK ONE ☐ BILL PATIENT* **Please attach insurance card or fill in the information below** ☐ BILL SUBMITTING INSTITUTION (** Add billing information below)

**For outside consultation services the patient's insurance information must be supplied if the patient is to be billed. If payment is denied by the patient's insurance, you will be responsible for payment for services. Please visit the Washington University Physicians website physicians.wustl.edu to verify the accepted health insurance carriers.*

Insurance Carrier:	Policy#: Group#:	Name of Policy Holder:	Relationship to Patient:	
Insurance Carrier Address:		City:	State:	Zip:

COLLECTION/REPORTING INFORMATION - COMPLETE ALL FIELDS

Requesting Physician Last Name:		First Name:	NPI #:
Phone:	Fax:	Date of Request:	
**Institution/Department Name & Address:		**City:	**State: **Zip:
**Institution/Department Phone:		**Institution/Department Fax:	
Copy To Additional Physician Name:		Phone:	Fax:
ICD10 Code(s):			
CLINICAL HISTORY:			
Specimen(s)/Outside Case #(s):			
Prepared Slides (#)*: **Recut slides preferred to allow for retention by WashU Faculty*		Unstained slides (#)**: ***Blocks are preferred*	
Blocks (#) and Description:			

ACKNOWLEDGEMENT

I acknowledge that Washington University will become the custodian of all material submitted with this consultation request for 30 days post sign out. Materials will be returned by standard US mail, unless a FED EX or UPS account number is provided.

INFORMED CONSENT CERTIFICATION

Submission of an order for pathology consultation and report constitutes certification to Washington University ("WU") that referring physician acknowledges that such consultation will result in the issuance of a report and could require additional testing. Referring physician further represents that: (1) "Informed Consent" has been obtained from subject patient as required by any applicable state or federal law with respect to each test contained in WU's test menu that may need to be performed; (2) authorization has been obtained from subject patient permitting the referring physician to seek a consultation from WU (and for WU to report results directly to the referring physician); and (3) the subject patient has acknowledged that any such request for a consultation may lead to additional charges for such consultation and/or additional testing and, if required, the subject patient has agreed to pay such amounts.

Signature:	Date:

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):

INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at 314-362-5641 or via e-mail at path-billing@email.wustl.edu for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):

CPT Codes and Units Authorized:

SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our Patient Accounts Manager office at 314-362-5641 or via e-mail at path-billing@email.wustl.edu.

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

Institution Name:

Contact Name:

Email:

Billing Address:

City:	State:	Zip:

Phone:	Fax: