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	✔

SEND PACKAGE(S) TO:

FedEx, UPS, US MAIL:

WashU Medicine
Department of Pathology & Immunology
Clinical Support Office
425 S. Euclid Ave. | MSC 8024-14-04
St. Louis MO 63110
Tel: (314) 747-1100 | Fax: (314) 362-4080

COURIER:

WashU Medicine
Department of Pathology & Immunology
Clinical Support Office
509 S. Euclid Ave. | West Bldg. | 4th floor
St. Louis MO 63110
Tel: (314) 747-1100 | Fax: (314) 362-4080

Office use only

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):		Sex: ☐Male ☐Female
Address:			City: State:	Zip:
Phone:			Doctor-Patient Appointment Date/Time:	

BILLING INFORMATION - COMPLETE ALL FIELDS

PLEASE CHECK ONE ☐BILL PATIENT ☐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's Physicians website to verify the accepted health insurance carriers by visiting the WashU Physicians website: https://wuphysicians.wustl.edu/for-patients/accepted-health-insurance/all-accepted-health-insurance-plans

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

COLLECTION/REPORTING INFORMATION - COMPLETE FIELDS

Requesting Clinician 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 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	Adhesive Used:
Blocks (#) and Description:	Fixative:	

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 of 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 preformed: (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):

BILLING INFORMATION
(CHECK ONE)

☐ **Bill Patient/Insurance-Complete Section A** ☐ **Bill Submitting Institution-Complete Section B**

SECTION A-PATIENT/INSURANCE BILLING INFORMATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. For MEDICAID patients, Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered services. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at (314) 362-5641 or via email 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 Unit Authorized:	

ATTACH COPY OF INSURANCE CARD (if not available, complete the following)

Policy Holder's Name			Insurance Co. Name:	
Last:	First:	MI:	Insurance Co. Phone:	
Policy Holder's Date of Birth (mm/dd/yyyy):			Plan Name:	
Relationship to Patient:			ID#:	Group#:

SECTION B-INSTITUTIONAL BILLING

Institution Name:		
Contact Name:	PO Number (if applicable):	
Email:		
Accounts Payable Billing Address:		
City:	State:	ZIP:
Phone:	Fax:	