



**JHML PATHOLOGY CONSULTATION  
Patient Demographic and Billing Form**

Please fill out the information below and print this form. Select one:

**Bill Institution**

|                                   |          |           |
|-----------------------------------|----------|-----------|
| Referring physician's name:       |          | NPI#      |
| Address:                          |          | City:     |
| State:                            | Country: | Zip Code: |
| Phone:                            | Fax:     | E-Mail:   |
|                                   |          |           |
| Patient's name and date of birth: |          |           |

**Bill Patient**

|          |                           |            |
|----------|---------------------------|------------|
| Name:    |                           |            |
| Address: |                           | City:      |
| State:   | Country:                  | Zip Code:  |
| Phone:   | Fax:                      | E-Mail:    |
| SSN      | Date of Birth: mm/dd/yyyy | Sex: M / F |
|          |                           |            |

Bill patient's primary insurance. **Medicare patients, please list secondary insurance**

|                          |               |                  |
|--------------------------|---------------|------------------|
| Company:                 |               | Phone:           |
| Address:                 |               | Name of Insured: |
| Address of insured:      |               |                  |
| Policy Number:           | Group Number: | Effective Date:  |
| Referring Physician NPI# | Fax:          | E-Mail:          |



**JOHNS HOPKINS**  
PATHOLOGY

Consult requested by:    Pathologist    Clinician    Patient    Other: \_\_\_\_\_

Patient clinical history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for consultation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific questions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Working diagnosis \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**MATERIAL SUBMITTED:**

Slides: (specify cases numbers and number of slides submitted)

Blocks: (specify case numbers and number of blocks submitted)

Recuts (may be retained by JHML)

Other: \_\_\_\_\_

Which material can be retained by us?

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Which material needs to be returned to you?

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***Note: patient and/or insurance provider may be contacted.***

Pricing or billing info please contact Shirley Myers at [smyers4@jhmi.edu](mailto:smyers4@jhmi.edu)