HPV BILLING INSTRUCTIONS

In order to bill patients or their insurance for outside slide consultation we need to be provided with the following information from the requesting institution:

1. Patient’s name as it appears on the insurance card. Patient's birth date, and address and telephone number.

2. Insurance information including the name and birth date of the person holding the insurance policy. Example if a wife is on her husband's policy we will need his name and birth date.

3. For patients who have a PPO, HMO or have a managed care contract with the requesting hospital or lab, JHU pathologist will need an authorization to do the work. If we do not have authorization, we will bill the institution.

4. If the patient is a self pay, payment may be made at the time of the request. If it is a charity case from the requesting hospital, we will not bill the patient --- only the requesting hospital or lab.

5. If the patient has Medicaid in the requesting hospital's state, we do not have provider numbers and cannot bill Medicaid for other states. We will bill the requesting hospital or lab.

Also **CONSULTATION CASES SENT BY AN OUTSIDE INSTITUTION:**

Send **slides, blocks, x-rays** and outside pathology report (must have a pathology report for each case submitted, or indicate if report is not final pending results of consultation sent for review) by Airborne (800-247-2676), Federal Express (800-463-3339), or UPS (800-741-5877).
DO NOT SEND BY REGULAR MAIL.

Send to:
The Johns Hopkins Medical Institutions
Anatomic Pathology Consultation Service
1620 McElderry St
Reed Hall Room 315
Baltimore, MD 21205
Telephone: 410-955-2405
Fax: 410-614-7712

The following information is needed before the consultation can be processed:
1. Billing information, bill patient or institution. See above for details.
2. Name, address, telephone and fax number of the physician requesting/submitting the consultation for review.

The normal turnaround time for results is 7 days unless additional studies are needed. Slides are held 10-30 days (60 days if patient is seeking treatment at Johns Hopkins) and then returned. Slides may be returned before that time upon receipt of authorization. Fax request to 410-614-7712.

WET TISSUE
Forward samples by courier or express mail to:
Johns Hopkins Medical Laboratories
Department of Pathology
Meyer B-130
600 N. Wolfe Street
Baltimore, MD 21287-7070

Attention: Dr. Westra
Insurance / Billing Information

Referring Physician / Institution Information
Name of Referring Physician___________________________    Referring Phys. UPIN#__________
Name of Referring Institution__________________________
Address line #1______________________________________
Address line #2______________________________________
City, State, Zip______________________________________

Name of ( ) Policy Holder and/or ( ) Guarantor ( ) Corporate Account

Mailing Address (Street/Apt. #)
City: ___________________________ State: _______ Zip Code: ________ Country: __________
Telephone Number: ______________________ Social Security Number of Policy Holder: __________

Patient’s Relationship to Policy Holder/Guarantor:
( ) Self ( ) Spouse ( ) Child ( ) Other:
Patient’s Date of Birth: ______________________

Diagnosis/Patient’s Chief Complaint:

Blue Shield Number: _______ _______ _______ _______ _______ _______
Medical Assistance Number: _______ _______ _______ _______ _______
Medicare Number: _______ _______ _______ _______ _______ Letter: ______________________
Name of Insurance Company: _________________________

Street Address:
City: ___________________________ State: _______ Zip Code: ________ Country: __________
Policy Number: ___________________________ Group Number: ___________ HMO Authorization Number: ___________
Name of Policy Holders Employer:

Signature of Patient or Guarantor Required
I acknowledge my responsibility for the payment of all charges for these laboratory services requested on my behalf by
my physician and authorize the release of information, including medical information for this or any related claim, to
the named insurance company. I promise to pay upon the receipt of the bill, charges for these services which are not
covered by insurance, not authorized by my Health Maintenance Organization or are only partially covered by
insurance.

Signature of Subscriber/Beneficiary or Guarantor _______________ Date Signed __________