

**Johns Hopkins Medical
Laboratories**
1620 McElderry Street
Reed Hall, Room 315
Baltimore, MD 21205
Phone 410-955-2405
Fax 410-614-7712



Instructions

Thank you for your interest in Johns Hopkins. To obtain a second opinion regarding a diagnosis you may have received, please carefully read and complete all sections of this document.

The first section of this form contains the insurance information. The second section will provide us with information about your history as it related to this consultation.

After completing all the sections of this form, please print the pages. Send this form along with your pathology report, glass slides and pertinent paraffin blocks via Federal Express, UPS or priority mail with a signature of receipt required addressed to:

**The Johns Hopkins Medical Laboratories
Anatomic Pathology Consultation Service
1620 McElderry Street
Reed Hall, Room 315
Baltimore, Maryland 21205**

If you have any questions, please call 410-955-2405 or 800-997-5475 (press 1).

JHML PATHOLOGY CONSULTATION
Patient Demographic and Billing Form



Section One: Patient Information

Please fill out the information below, print this form, and include with the letter to your surgeon.

Name:

Address:

Address:

City:

State:

Country:

Zip/Country Code:

Phone:

Receive 2nd opinion report via

Fax:

US mail

SSN:

Date of Birth:

Gender: M F

Section Two: Billing Information



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

The cost of a second opinion from Johns Hopkins may be covered by your insurance. If you have an HMO or preferred provider organization (PPO) coverage, you will need an authorization to have a second opinion done by Johns Hopkins University Reference Laboratories. Medicare will cover a second opinion requested by a physician.

Please select one:

Bill patient's home address as above (*patient may be contacted*)

Bill patient's primary insurance.

Bill Medicare (Medicare patients, please list secondary insurance.)

Company Name:

Company Phone:

Company Fax:

Group Number:

Policy Number:

Effective Date:

Company Address:

Company Address:

Company City:

Company State:

Company Country:

Company Zip:

Section Two: Billing Information (continued)

Name of Insured:

(if address of insured is different than above, please provide here)

Insured Address:

Insured Address:

Insured City:

Insured State:

Insured Country:

Insured Zip:

Referring Physician NPI#:

Referring Physician Fax:

Referring Physician E-mail:

Secondary Insurance for Medicare patients:

This consult was requested by (check one):

Pathologist

Clinician

Patient

Other:

Please provide some background in the fields below:

Reason for consultation:

Specific questions

How did you hear about us?

Google

Bing, Yahoo, MSN, other Web site

Physician recommendation

Other