PML PATHOLOGY

PATHOLOGY CONSULT REQUEST

REQUESTOR'S CONTACT INFORMATION

Name of Physician Requesting this consult & NPI: _____

Name of Facility: _____

Address:_____

City, state, zip code: _____

Phone: _____ e-mail address: _____

Cell: _____ Fax: _____

PATIENT DEMOGRAPHICS *(you can send print-out of pt face sheet in lieu of completing this section)*

Patient Name_____
Patient D.O.B. _____
Address _____
Phone _____

If patient is a minor, please complete for Parent or Legal Guardian:

Name (relation to patient) _____
Address_____
Phone _____
D.O.B. _____

* Please provide a cover letter with any pertinent information on patient and all relevant Pathology reports.

BILLING OPTIONS – CHOOSE 1, 2 or 3:

1. Bill Patient's Insurance/Medicare/Medicaid* - ***Only IL, IN, and WI Medicaid are accepted*:**

   Company name _____

   Group Number _____

   Policy/ID Number _____

   (Please provide a clear copy of the front and back of card)

2. Bill your practice (i.e. Doctor Billing)? _____ (if you're a new acct, please provide billing address, billing contact name, email address and direct phone number for billing inquiries)

3. Bill the patient directly (i.e. Self-Pay)? _____

PML Pathology
10 Medical Park Dr, Asheville, NC 28803
Phone: 828-253-0762 Fax: 828-254-4892