# UCSF PATHOLOGY Muscle/Nerve CONSULTATION SERVICE

## Billing Information Form

**Fax to: 415-476-7963**
**Questions: 415-476-5236**

**Thank you for sending us a case for consultation.** Please complete and send this form with your next consultation request, as the information requested will facilitate and expedite the consult process. **Please send this completed form with the patient's tissue and any history on the patient (see UCSF Muscle/Nerve Biopsy Requisition Form)**

**Requesting/Referring Physician**

Physician's first and last name: ______________________________

Reporting address: ______________________________

Telephone: ____________________ Fax: ____________________

**Patient Information**

Patient's first and last name: ______________________________

Birth date: ______________ Gender: ______ SS#: ______________

Home address: ______________________________

Telephone: ____________________

**Billing Information**

Please bill: (check one)

_____ Hospital

_____ Patient (Self pay)

_____ Insurance **(Please attach patient's insurance information and authorization (HMO's, some POS, and certain medical groups) for insurances that require prior authorization. Authorization should be a print out from the insurance company with authorization #, effective dates and CPT codes authorized. UCSF does not accept Medicaid)**

**Your Contact Information**

Name: ______________________________
Telephone: ____________________

*UPDATED 10/1/12*