UCSF Health

DEPARTMENT OF PATHOLOGY CONSULT REQUISITION

1600 Divisadero Street, Room R200
San Francisco, CA 94115
Phone: (415) 353-1613 Fax: (415) 353-7276
Email: pathology-consult-services@ucsf.edu

MRN:

PT. NAME:

BIRTHDATE: GENDER:

CLINIC:

VISIT #:

All REQUIRED fields and documents MUST be submitted to avoid any delay in test results. A copy of the Pathology Report or preliminary with gross description is REQUIRED.

Requesting Facility/Clinic *(REQUIRED)*

Ordering/Referring Provider: _____ NPI: _____ Phone _____ Fax: _____

Address: _____

Sender's Name: _____ **Phone:** _____

Bill To *(REQUIRED)* *(Check One Only)*:

☐ Patient SELF PAY (Pay out of pocket) ☐ Referring Facility ☐ PPO ☐ HMO ***(REQUIRED for CPT codes:88321, 88323, 88312, 88313, 88341, 88342, 88360. Please include authorization letter)***

☐ Medicare - *For consult within 14 days of surgery,* ***Medicare requires consultants to bill the referring facility for technical charges****. Please indicate below which facility is responsible:*

Facility Name: _____

Date of Surgery: _____

ICD-10 code(s) is/are necessary to indicate medical necessity and for billing purposes. If payment is denied by insurance, referring facility is required to obtain a signed Advance Beneficiary Notice (ABN) which acknowledges patient responsibility for payment.

ICD-10 CODE *(REQUIRED)*	RELEVANT CLINICAL HISTORY / CONSULT QUESTION:

Consult Slides/Blocks *(REQUIRED)* *(Providing blocks and/or unstained slides may expedite a final report):*

Specimen #: _____	Specimen #: _____	Specimen #: _____
☐ Stained Slide Count _____	☐ Stained Slide Count _____	☐ Stained Slide Count _____
☐ Paraffin Block Count _____	☐ Paraffin Block Count _____	☐ Paraffin Block Count _____
☐ Unstained Slide Count _____	☐ Unstained Slide Count _____	☐ Unstained Slide Count _____

Special Instructions/Comments:

678-002 (Rev. 10/19) PATHOLOGY DEPARTMENT COPY