UAB MEDICINE

**International Patient Billing Information**

# PATHOLOGY INTERNATAIONAL CONSULTATION REQUEST FORM

## PATIENT DEMOGRAPHIC INFORMATION

(Please complete this form and return along with related Pathology report(s) and material(s). It is recommended that slides and tissue blocks be submitted.
Patient's Name (s) and Date of Birth must match report (s) and appear as entered on legal documents such as passports and/or driver's license.)

| | | |
|---|---|---|
| LAST NAME: | FIRST NAME: | MIDDLE INITIAL: |
| ADDRESS: | | |
| CITY: | STATE/COUNTRY: | ZIP/COUNTRY CODE: |
| PHONE: | FAX: | EMAIL: |
| Date of Birth: **Month/Day/Year** | MARITAL STATUS: Married ☐ Single ☐ | GENDER: Male ☐ Female ☐ |

## REQUESTING PHYSICIAN INFORMATION

(Please provide complete mailing address of physician in which to forward patient report)

| | | |
|---|---|---|
| NAME: | | |
| SPECIALTY: | | |
| INSTITUTION NAME: | | |
| ADDRESS: | | SUITE: |
| CITY: | STATE/COUNTRY: | ZIP/COUNTRY CODE: |
| PHONE: | FAX: | EMAIL: |

**Financial Obligations**

Below are the services that we provide. **IMPORTANT** - Consultations cannot be processed without credit card payment information. By providing this information, you are authorizing Pathology to post charges to your credit card(s) without having to provide you with advanced notification of charges being made.

**Please note that any incomplete patient or billing information will delay processing of your request.**

**Service**

Evaluation of pathology materials by a pathologist including any required ancillary studies (i.e. IHC, Molecular) followed by a formal report.

**Cost**

It is not possible to know the actual cost prior to review of materials. Ancillary studies may be required, which will incur costs in addition to the initial review.

## BILL CREDIT CARD

| | | |
|---|---|---|
| TYPE: PLEASE SELECT | CARD NUMBER: | EXPIRATION DATE: |
| CVV: | CARD HOLDER'S NAME: | Name should be entered as it appears on card<br>*I authorize UAB Medicine, Department of Pathology to charge the above credit card for this consultation* |
| CARD HOLDER'S SIGNATURE: | | |

**ALTERNATE CREDIT CARD**

| | | |
|---|---|---|
| TYPE: PLEASE SELECT | CARD NUMBER: | EXPIRATION DATE: |
| CVV: | CARD HOLDER'S NAME: | Name should be entered as it appears on card<br>*I authorize UAB Medicine, Department of Pathology to charge the above credit card for this consultation.* |
| CARD HOLDER'S SIGNATURE: | | |