

<b>Hospital Pathology Associates Consultation Center</b> 2800 10 <sup>th</sup> Ave S, Ste 2200, Minneapolis, MN 55407 Phone 612-767-8370 / fax 612-767-8376	Bill to: ___ Clinic/facility ___ Insurance ___ Patient (self pay)
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I N S U R A N C E	Patient Name: (Last) _____ (First) _____ (MI) _____		
	SSN _____	___ Male ___ Female	DOB _____ / _____ / _____
	Patient Address(Street) _____		
	City _____	State _____	Zip _____ Patient Phone # _____
	___ Medicare Primary ___ Medicare Secondary		
	Medicare Number _____ Suffix _____		
	Medicaid Number _____ State _____		
	Relationship to insured ___ Self ___ Spouse ___ Dependent		
	Policy Holder _____		Policy Holder Date of Birth: _____
	Member/Insured ID# _____		Group # _____
Insurance Company Name _____			

Signature of requesting Pathologist/Physician _____	Insurance Co Address _____
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NPI: \_\_\_\_\_

<b>CMS regulations and guidelines state that it is necessary for performing laboratories to maintain written documentation of all orders. In order to assure compliance, we require the ordering physician's signature.</b>	<b>No testing can occur until this form is received by HPA</b>
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**Clinical Information & History**

Date of Request _____ Specimen Source _____ Reason for Consultation _____ Additional Comments _____ _____	Ordering entity a hospital? ___ Yes ___ No Note: Hospitals will be billed for all technical charges. Working Diagnosis _____ _____ _____
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**Material Submitted**

Hospital of Origin _____	
Hospital Address _____	
City _____	State _____ Zip Code _____
Phone _____	Fax _____
<b>Slides:</b>	Transported in: ___ Saline ___ Transport Media (Specify) _____ ___ Formalin _____ ___ Other (please specify) _____
Path # _____ # of Slides _____ Collection Date _____	
Path # _____ # of Slides _____ Collection Date _____	
Path # _____ # of Slides _____ Collection Date _____	
<b>Blocks:</b>	
Path # _____ # of Blocks _____ Collection Date _____	
Path # _____ # of Blocks _____ Collection Date _____	
Frozen tissue: Path # _____ Collection Date _____	
Wet Tissue: Path # _____ Collection Date _____	