

Hospital Pathology Associates Consultation Center 2345 Rice St Suite 160, St Paul, MN 55113 Phone 651-483-2033 / fax 651-483-1734		Bill to: ___ Clinic/facility ___ Insurance ___ Patient (self pay)	
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	
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.		No testing can occur until this form is received by HPA	
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 _____ _____ _____	
Material Submitted			
Hospital of Origin _____			
Hospital Address _____			
City _____		State _____ Zip Code _____	
Phone _____		Fax _____	
Slides:		Transported in: ___ Saline ___ Transport Media (Specify) _____ ___ Formalin _____	
Path # _____ # of Slides _____ Collection Date _____		___ Other (please specify) _____	
Path # _____ # of Slides _____ Collection Date _____		_____	
Path # _____ # of Slides _____ Collection Date _____			
Blocks:			
Path # _____ # of Blocks _____ Collection Date _____			
Path # _____ # of Blocks _____ Collection Date _____			
Frozen tissue: Path # _____ Collection Date _____			
Wet Tissue: Path # _____ Collection Date _____			