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Boston Children's Hospital

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ANATOMIC PATHOLOGY CONSULT REQUISITION

BCH PATHOLOGY LABEL

DEPARTMENT OF PATHOLOGY – Farley 190 - BCH3027
300 LONGWOOD AVENUE, BOSTON, MA 02115 | PHONE: 617-355-7431 | FAX: 617-730-0207
EMAIL: pathfrontoffice-dl@childrens.harvard.edu

PATIENT INFORMATION: **(PLEASE PRINT IN BLACK INK)**

LAST NAME	FIRST	MI

ADDRESS	CITY	STATE	ZIP

BIRTH DATE	SEX	PHONE	PATIENT ID #

REQUESTOR:

NAME

ADDRESS

PHONE

ORDERING PHYSICIAN CONTACT INFORMATION:

PHYSICIAN NAME

PHYSICIAN NPI (NON-BCH PROVIDERS)

PHYSICIAN PHONE

PHYSICIAN EMAIL

CC PROVIDER:

REQUESTOR SIGNATURE

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital Discharge Date:

A prior insurance authorization may be required. Denied claims for any reason will be billed to the requestor.

ICD-10 Diagnosis Code Required: 1. _____ 2. _____ 3. _____

Clinical Information: Please provide all mandatory clinical information listed on instruction sheet.

BRIEF CLINICAL HISTORY

SPECIMEN INFORMATION:

COLLECTION DATE	CLIENT CASE NUMBER(S)	SOURCE

☐ Blocks Qty: _____ ☐ Stained Slides Qty: _____ ☐ Unstained Slides Qty: _____ ☐ Other Qty: _____

BILL TO: ☐ Patient Insurance ☐ Requestor ☐ Patient Self-Pay *Insurance Carrier:* _____

Charges for patients classified as a hospital "inpatient or "outpatient" at the requesting facility on the date of service must be billed to the requesting facility unless an appropriate exception applies. SSA §1833(h)(5)(A); SSA §1833(h)(5)(A)(iii); SSA §1861(w)(1); 42 §CFR 414.510

SUBSCRIBER LAST NAME	FIRST	MI	INSURANCE PHONE	BENEFICIARY/MEMBER #

CLAIMS ADDRESS (IF AVAILABLE)	CITY	STATE	ZIP	GROUP # (IF AVAILABLE)