Brigham and Women's Hospital
Founding Member, Mass General Brigham

**Mihm Cutaneous Pathology Consultative Service**

**Adriano Piris, MD**
Medical Director

Department of Dermatology
41 Avenue Louis Pasteur
Suite 317
Boston, MA 02115
T 617 264 3030
F 617 264 3013
E mihmconsults@bwh.harvard.edu

# DERMATOPATHOLOGY CONSULTATION REQUEST FORM

Please send:

☐ Slides/Blocks ☐ Pathology Report

☐ Completed Form ☐ Patient Insurance/Demographic Information

Patient Information:

| | |
|---|---|
| Patient Name: | |
| DOB: | Gender: |
| Site of Biopsy: | |
| Case Number: | |
| Total Slides | Blocks: |

Results should be sent to:

| |
|---|
| Physician Name: |
| Company: |
| Address: |
| |
| |
| |
| Phone: |
| Fax: |
| Email: |

Please Indicate Who Should be Billed:

☐ Bill Client/Healthcare Institution

| | | |
|---|---|---|
| Client Name: | | |
| Physician/Guarantor: | | |
| Billing Address: | | |
| City: | State: | Zip |
| Name of Billing Contact: | | Phone #: |
| Email: | | |

☐ Bill Patient

| | | |
|---|---|---|
| Primary Insurance Company: | | Ins. Phone: |
| Insurance Address: | | |
| Name of Subscriber: | | |
| Date of Birth of Subscriber: | Relationship to Patient: | |
| Address of Insured: | | |
| City: | State: | Zip: |
| Policy ID: | | |
| Group #: | | Effective Date: |

| | | |
|---|---|---|
| Secondary Insurance Carrier: | | Ins. Phone: |
| Insurance Address: | | |
| Name of Subscriber: | | |
| Date of Birth of Subscriber: | Relationship to Patient: | |
| Address of Insured: | | |
| City: | State: | Zip: |
| Policy ID: | | |
| Group #: | | Effective Date: |

My signature indicates that I agree to pay all consultation fees and costs associated with completing this consultation. I understand that if the patient's insurance is billed, the patient will be responsible for any co-pays, deductibles, and/or to provide payment in full if the claim is denied by their insurance for whatever reason.

Physician/Office Administrator Signature: _____

Please Print Name: _____