Instructions

Patients who have their slides

Please complete as follows:

1. The first section of this form contains the necessary patient information.
2. Section 2 should be completed by your physician, should you want us to bill your insurance.
   a. Insurance and Medicare will not pay for 2nd opinions at the request of the patient.
   b. We do not accept Medicaid from states other than Maryland.
3. Section 3 must be completed so that your insurance may be billed.
4. The last page is a HIPAA release form, required for us to provide you with a copy of your report.
5. Self-pay patients, complete and print section 1, the HIPAA form and send along with your pathology slides.
6. For consultations billed to insurance, complete and print Sections 1, 2, 3 and the HIPAA form.
7. Ship slides and paperwork to:

   The Johns Hopkins Hospital
   600 N. Wolfe Street
   Cytopathology Consult Service
   Pathology, Room 412D
   Baltimore, MD 21287-6940
   Tel: 410.955.3520
   Fax: 410.955.3438

8. We recommend a courier with proof of receipt such as FedEx or UPS.
9. Glass slides must be properly packaged to avoid breakage during transit.

Consult Fee  one of the following two choices will be charged

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>88321</td>
<td>2nd Opinion Consult, slides only</td>
<td>$250</td>
</tr>
<tr>
<td>88323</td>
<td>2nd Opinion Consult, slides and blocks</td>
<td>$350</td>
</tr>
</tbody>
</table>

* The majority of cases are billed as 88321, $250.
In some cases additional testing may be required. Associated fees may be incurred.
Patient Information – Section 1

Patient request for a pathology consult, self-pay;
Complete Section 1, to pay by credit card, call 410-933-1306.

To have charges billed to your insurance, the request for consultation must be made by your physician. Ask your physician to complete Sections 2 and 3, and submit the documents with the glass slides.

The cost of a second opinion from Johns Hopkins may be covered by your insurance. If you have an HMO or preferred provider organization (PPO) coverage, you will need an authorization to have a second opinion done by Johns Hopkins University Reference Laboratories. Medicare will cover a second opinion requested by a physician along with a medical reason why it was sent for a consult. Note: patient and/or insurance provider may be contacted.

Patient’s Name: _________________________________________
Address: ________________________________________________
Address: ________________________________________________  State: _____  Zip: ______
City: ____________________________________________________
Phone: ________________________________  Social Security # _______________________
Date of Birth: ________________________________
Cell #: ________________________________
Gender:  ○ Male  ○ Female  Email ________________________________

Patient’s Reason for consult:
________________________________________________________________________

Patient’s Specific Questions:
________________________________________________________________________

Would you like a copy of this report sent to your physician?  ○ Yes  ○ no

Physician’s Name _____________________________________________
last name,  first name  title
Address ________________________________________________________
Address ________________________________________________________
City___________________________  State _____  Zip ________________
**To have charges billed to insurance this form must be completed by your physician.**

Section 2

Consult requested by Clinician

Physician Name ________________________________ NPI# __________________

Address ______________________________________________________________

Address ______________________________________________________________

City _____________________ State ___ Country ________________ Zip ________

Phone ___________ Fax ___________ Email ________________________________

Patient’s Name __________________________________ Date of birth

Patient’s clinical history:

________________________________________________________________________

Reason for consultation / specific questions (required)

☐ To verify the diagnosis and or grade for treatment purposes.

☐ To resolve an equivocal diagnosis for treatment purposes.

☐ To resolve a clinical-pathological discrepancy for treatment purposes.

☐ Other

Working diagnosis:

________________________________________________________________________

Requesting Physician signature ___________________________ Date __________

MATERIAL SUBMITTED: specify case numbers

Total number of slides: Case number/s

Total number of blocks: Case number/s

Other material:

Which material needs to be returned to you? ☐ all ☐ none

Recuts (may be retained by JHML)? ☐ yes ☐ no
**Insurance Information - Section 3**

Name of Patient: __________________________________________

Name of Insured: __________________________________________

Relationship to Patient: _______________ Date of Birth of Insured: _______________

*(If address of insured is different than the patient’s address, please provide here)*

Insured Address: __________________________________________

Insured Address: __________________________________________

Insured City: _______________ State ___ Country _____________ Zip ___________

**Primary Insurance**

Insurance Company Name __________________________________________

Insurance Company Phone _______________ Insurance Company Fax _______________

Group Number _______________

Policy Number _______________

Effective Date _______________

Insurance Company Address (on back of card)

____________________________________________________________

Insurance City _______________ State _____ Country _____________ Zip _______

**Secondary Insurance**

Insurance Company Name __________________________________________

Insurance Company Phone _______________ Insurance Company Fax _______________

Group Number _______________

Policy Number _______________

Effective Date _______________

Insurance Company Address (on back of card) _______________

____________________________________________________________

Insurance City _______________ State ___ Country _____________ Zip _______
# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

- NOT TO BE USED IN CONNECTION WITH HEALTH INFORMATION FROM SUBSTANCE ABUSE TREATMENT OR MENTAL HEALTH PROGRAMS.

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th></th>
<th></th>
<th>Birth Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(first)</td>
<td>(m. initial)</td>
<td>(last)</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>(street address)</td>
<td>(city)</td>
<td>(state)</td>
</tr>
<tr>
<td>Medical Record #:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I understand there may be a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland guidelines. By signing this authorization, I agree to pay these fees at the time this request is made.

I understand that:
- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, Johns Hopkins will not disclose My Health Information as requested.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: ______________. I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the clinic or department where my authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

<table>
<thead>
<tr>
<th>Signature of Patient only:</th>
<th>Date:</th>
<th>(Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, _________________________________ (print your name), confirm that I am the legally appointed representative for the patient and I have CIRCLED my relationship to the patient below:

- Parent with Parental Rights
- Registered Kinship Care Relative
- Court Appointed Guardian
- Legally Appointed Healthcare Agent
- Medical Power of Attorney
- Power of Attorney with Right to See Medical Records
- Surrogate Decision Maker
- Court Appointed Personal Representative of Deceased

Representative’s Signature: ________________________________ Date: ______________ (Required)
Address: _____________________________________________ Phone: __________________________
You must attach proof of your authority to act on behalf of the patient as circled above (other than parent).