CONSULTATION REQUEST FORM

DATE OF REQUEST:

_____

CLIENT NAME: _____

PATIENT NAME: _____

ACCESSION # / BLOCK ID: _____

TEST (S) REQUESTED: _____

DATE OBTAINED: _____

REQUESTED BY: _____

RESPONSIBLE PARTY
FOR BILLING _____

Federal Regulations #493.1105 requires written authorization for all laboratory test add-ons and consultations, to be submitted within 30 days of the verbal request to the referring laboratory. Please return this form to Bio-Path Medical Group with your authorization signature.

PHYSICIAN AUTHORIZATION_____

Please fax, mail or to give to a Bio-Path courier.

Bio-Path Medical Group
17150 Newhope Street #117
Fountain Valley, CA 92708

Phone # 714-433-1330
Fax # 714-755-2984

FOR LAB USE ONLY

LABORATORY_____ DATE_____

REC./ D.E._____ DATE_____

ACCESSION #_____ DATE_____