SBMF
South Bend Medical Foundation

Department of Pathology
3355 Douglas Road, South Bend, IN 46635
Phone 574-234-4176 **Fax** 574-807-3162
www.sbmf.org/downloads

OUTSIDE PATHOLOGY CONSULTATION REQUEST

Please provide the information below. If this information is not completed, it may lead to the case being returned without review.

PATIENT INFORMATION

Last Name: ______________________________

First Name: ______________________ MI: ______

Gender: ☐ Male ☐ Female Date of Birth (mm/dd/yyyy) ____________

Address: ______________________________

City: ______________ State: ______ Zip Code: ______

Phone: ____________________

ORDERING PHYSICIAN INFORMATION

Client/Institution Name: ______________________________

Ordering Physician: ______________________________

NPI #: ______________________________

Address: ______________________________

City: ______________ State: ______ ZIP Code: ______

Phone: ______________ Fax: ______________

Additional fax to: ______________________________

BILLING INFORMATION

Medical Necessity Notice:
Please be aware that insurance companies may require a determination of medical necessity before approving coverage for the release of pathology slides and reports. If insurance denies payment, the patient or requestor may be responsible for the full cost of services rendered.

BILL TO: ☐ Client/Institution ☐ Insurance ☐ Patient

Please attach complete demographic and insurance information.

Primary Insurance: ______________________

Secondary Insurance: ______________________

ICD-10 Code: ______________________________

Clinical History: ______________________________

Place of Service: ☐ Non-Hospital ☐ Outpatient
☐ Inpatient Discharge Date: ____________

SAMPLE/SPECIMEN INFORMATION

Purpose for Release: ☐ Continuation of care ☐ Second Opinion Consultation ☐ Other: ______________________

Accession #: ____________ Date of Collection: ____________ Bodysite: ____________ # of Slides ____ # of Blocks ____

Accession #: ____________ Date of Collection: ____________ Bodysite: ____________ # of Slides ____ # of Blocks ____

Accession #: ____________ Date of Collection: ____________ Bodysite: ____________ # of Slides ____ # of Blocks ____

RETURN OF PATHOLOGY MATERIAL

Recipient Name: ______________________ Organization/Facility Name: ______________________

Address: ______________________ City: ____________ State: ______ Zip Code: ________

Phone Number: ______________________ Fax Number: ______________________

Requestor's FedEx Account Number*: ____________________

***A valid account number or shipping label is required to return outside material as SBMF does not assume responsibility for shipping costs. If you are unable to provide an account number or label, please select from the available options below or contact our office at (574) 234-4176 to discuss alternative arrangements.**

Please send slide(s), paraffin block(s) along with this request form to:

South Bend Medical Foundation
attn: Pathology Consults/Surgical Records
3355 Douglas Road, South Bend, IN 46635
Phone: (574) 234-4176 **Fax:** (574) 807-3162

Required information to be included in the package:

- This request form
- Patient Demographics & Insurance Information
- Clinical History
- Pathology material (Slides & Blocks)
- Original (and/or your institution's) pathology report

CONSENT FOR PATHOLOGY CONSULTATION AND ADDITIONAL TESTING

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

I, the undersigned, hereby authorize **South Bend Medical Foundation** to receive pathology slides, blocks, and related medical materials from the referring facility for consultation purposes. I understand that South Bend Medical Foundation will review the provided materials and may perform additional testing, including but not limited to molecular, immunohistochemistry (IHC), or genetic testing, if deemed necessary for diagnostic purposes.

AUTHORIZATION FOR ADDITIONAL TESTING

- I understand that SBMF will evaluate my case and may order additional testing, which may include special stains, molecular studies, or other diagnostic procedures as required.
- I acknowledge that some additional tests may incur separate charges, and I agree to be financially responsible for any such tests not covered by my insurance plan or preauthorized by my provider.

Please Note: In compliance with the CMS 14-Day Rule for molecular testing, SBMF will follow all applicable billing regulations. If applicable, testing may be delayed in accordance with these regulations.

RELEASE OF INFORMATION FOR PATHOLOGY CONSULTATION

- By signing below, I authorize the release of my pathology slides, blocks, and any related medical records to SBMF for the purpose of diagnostic consultation.
- I understand that SBMF may need to contact the facility that provided the materials for additional information, such as clinical history or other relevant details.
- I understand that SBMF may retain slides or tissue blocks for future reference and may return these materials to the referring facility upon completion of the consultation and any additional testing, if required.

Signature of Patient or Legal Guardian: ____

Printed Name: ____ **Date:** ________________