Expert Consultation Form

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PHYSICIAN INFORMATION

I am the sender of this material and agree this material will be kept at Metamark Laboratories until the studies are complete.

Date	

Full Name (Print)	Title	

Signature

FACILITY NAME AND ADDRESS: *(please complete if this field is empty)*

PATIENT INFORMATION

Patient Name	Accession/Case #

Street Address	Apt. #

City	State	ZIP	Phone #

Date of Birth	Age	Sex

Material Included in this Package:

□ Original Pathology Report **(REQUIRED)**
□ Wet Tissue
□ Cytology Smear

□ Tissue Sections/Slides
□ Paraffin Block

Number of Slides Sent: H&E: _____   IMMUNOS: _____

BILLING INFORMATION

Bill to: □ Insurance   □ Patient/Self-Pay   □ Client

Service Type: □ Global   □ TC   □ PC   □ TC with Global Bill   □ PC with Global Bill

Primary Insurance: (or attach card copy)	Policy #	Group #
Plan Name		Phone #
Plan Address		
Name of Subscriber		Patient Relationship to Subscriber

Secondary Insurance: (or attach card copy)	Policy #	Group #
Plan Name		Phone #

I authorize testing and confirm: 1) that this test is medically necessary and the results will be used in the medical management and treatment decisions for the patient; 2) that informed consent has been obtained; and 3) that I have on file the patient's assignment of benefits authorizing insurance benefits to be paid to Metamark Genetics, Inc. (Metamark). I authorize Metamark to contact the patient, if necessary, for testing authorization and discussion of financial responsibility. I authorize Metamark to release the information on this form and other information provided by me that is necessary to process a claim for this service.