

Yale Pathology Labs

Pathology Consultation Requisition Form

For final reports or any questions please call 203-785-2788

Patient Name: _____

Office Hours 9:00 am - 5:00 pm, Monday - Friday

Patient DOB: _____

Leave message for after hours

REFERRING PHYSICIAN & ORDERING INSTITUTION INFORMATION

Referring Physician Name	Referring Physician NPI#	Referring Physician Telephone	
Institution Name	Telephone	Fax	
Address	City	State	Zip Code
Point of Contact Name	Point of Contact Email	Point of Contact Telephone	
Institution Billing Contact Name	Institution Billing Contact Email	Institution Billing Contact Telephone	

SPECIMEN INFORMATION

Indicate Pathologist Name or Service Line Requested:

Accession#	# of Slides	# of Blocks	Accession#	# of Slides	# of Blocks
Accession#	# of Slides	# of Blocks	Accession#	# of Slides	# of Blocks

BILLING/INSURANCE INFORMATION

Ordering Institution/Referring Physician

[Yale Medicine - Insurance Listing](#)

Please provide a shipping label or account number for return S&H of materials:

BILL TO:

Patient Insurance; **Yale Medicine Participating Carriers Only - No Out of State Medicaid**

Note: If non participating with Yale Medicine Insurance - Ordering Institution will be billed

Primary Insurance Company Name		Secondary Insurance Company Name	
Primary Insurance Policy #	Primary Insurance Group #	Secondary Insurance Group #	Secondary Insurance Policy #
Name of Insured for Primary	Telephone	Name of Insured for Secondary	Telephone
Relationship to Patient	DOB	Relationship to Patient	DOB
ICD-10 CODES		Insurance Pre-Authorization # (If applicable, i.e. V.A.)	

Consulting Services and Fee

88321: Consultation and report on referred slides prepared elsewhere; **CY26 Global Fee \$302**

88323: Consultation and report on referred material requiring preparation of slides; **CY26 Global Fee \$411**

88325: Consultation, comprehensive, with review of records and specimens, with report on referred material; **CY26 Global Fee \$656**

Additional Testing (as indicated by Pathologist)

88341: IHC, per specimen, each additional stain, per specimen; **CY26 Global Fee \$221**

88342: IHC, initial single antibody stain; **CY26 Global Fee \$251**

88312: Special stain; Group 1, **CY26 Global Fee \$141**

88313: Special stain; Group II; **CY26 Global Fee \$248**

81265: Trophoblastic Disease; STR Genotyping; **CY26 Fee \$607**

STR Genotyping Only please contact path.outreach.contract@mailman.yale.edu or pathmdx@yale.edu

This request to order tests from Yale Pathology Labs certifies that (1) the referring physician has obtained written informed consent from the patient as required by applicable state or federal laws for each test ordered, (2) the referring physician has authorization from the patient as required by applicable state or federal laws permitting YPL to provide the service and report results to the referring physician and (3) ordering institution is responsible for obtaining pre-authorization from the payer if required. If the consultation request form is incomplete, the slides will not be reviewed until all required information is complete. If Yale is not contracted with the patient's insurance, if the patient is uninsured, or if the Ordering Institution/Referring Physician is designated above to be billed, the ordering institution or the referring physician (if no institution is listed) will be invoiced for the services and will be responsible for payment. Payment will be made in accordance with the then-current fee schedule, which is updated on an annual calendar basis, in accordance with fair market value. In the event that a referring physician is submitting this form in his/her personal capacity or the ordering institution is a physician group, the term of this agreement shall be one year from the date of the signature below. If a consultation requisition form has been submitted by the same referring physician or ordering institution prior hereto, this request shall be deemed under the same arrangement as such earlier request(s) and shall extend the term of such arrangement by one year from the date of the signature below.

Required - Referring Physician/Pathologist Signature

Date