Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Anatomical Pathology, 330 Brookline Ave. Boston, MA 02215 | Phone: 617-667-4371 | Fax: 617-667-7120

INTERNATIONAL PATHOLOGY CONSULTATION PAYMENT AUTHORIZATION FORM

To: **From:** Consult Coordinator

Fax: **Date:**

Thank you for your request. We have received the pathology consultation with slides for patient,

_____.

In order to process your request, we first must advise you of our billing policy for international consults / second opinions and obtain a signed authorization for payment.

International consultations need to be paid in advance. The requesting party / institution will be charged $500USD per procedure date. Vendor and PO (s) are not acceptable forms of payment. If additional immunoperoxidase studies are required, there will be an extra charge.

- Prior to logging into website, contact our office, 617-667-4371, in order to obtain account # and password
- Log into secure website, www.peryourhealth.com, and enter the provided Account # _____ Password: ____ Patient's Date of Birth: 07/01/2011 (use this DOB as a default). Choose the "Make a Payment" option from the menu and enter the credit card information as appropriate.
- You will be prompted to create a One Healthcare ID to log into this site. That is due to the dual authentication that is required per our company policies

Once payment is made, please return form via fax or e-mail.

BILLING AUTHORIZATION (Please fill out each **required field)

_____ _____

****Name** of Responsible Billing Party / Facility **Authorizing signature**
(Date)

_____

****Billing Address (please indicate exact billing address & contact).**

_____ _____

****Transaction ID** (confirmation of payment) E-mail address

_____

Patient Identification (Name and DOB)