JOHNS HOPKINS MEDICAL INSTITUTIONS
DERMATOIMMUNOLOGY LABORATORY
Blalock Building - Room 918
600 N. Wolfe Street - Baltimore, MD 21287
Phone: (410) 955-2992 (800) 525-9303 Fax: (410) 955-0520

ORDERING PHYSICIAN INFORMATION	PATIENT INFORMATION
Required information	SPECIMEN COLLECTION DATE _____
FULL NAME _____	JOHNS HOPKINS HISTORY # _____
CLINIC/ DEPARTMENT _____	PATIENT NAME (Last, First) _____
STREET ADDRESS _____	SOCIAL SECURITY NUMBER _____
CITY/STATE/ZIP _____	DOB _____ AGE _____ SEX _____ RACE _____
	STREET ADDRESS _____
PHONE NUMBER _____	CITY/STATE/ZIP _____
FAX RESULTS TO _____	HOME PHONE _____ WORK PHONE _____

BULLOUS DISEASE TESTS

DESCRIPTION	CPT CODE	DESCRIPTION	CPT CODE
☐ Direct IF - Biopsy (IgA, IgG, IgM, C3 & Fibrinogen)	88346	☐ Herpes Gestationis Factor	86171
		☐ PNP - Paraneoplastic Pemphigus	83519
☐ Indirect IF - Serum (Pemphigus, BP & EBA)	88347	**NOTE:** **Please include patient's name and date of birth on the specimen vial.**	

CLINICAL HISTORY/DIAGNOSIS:

BIOPSY SITE

INSURANCE INFORMATION

PRIMARY INSURANCE ☐ Medicare ☐ Medicaid	SECONDARY INSURANCE ☐ Medicare ☐ Medicaid
☐ BC/BS ☐ Commercial Insurance (provide name) ☐ Self-pay	☐ BC/BS ☐ Commercial Insurance (provide name)
Membership # _____	Membership # _____
Group/Plan _____	Group/Plan _____
Subscriber Name (Last, First) _____	Subscriber Name _____
Subscriber Social Security # _____	Subscriber Social Security # _____
Commercial Insurance Name _____	Commercial Insurance Name _____
Street Address _____	Street Address _____
City/State/Zip _____	City/State/Zip _____

REQUEST MORE MAILERS:

☐ For Biopsies (Transport Media) ☐ For Federal Express

I am (or the minor or other individual for whom I am responsible is) enrolled in _____ ("Health Plan").

I understand that if appropriate, Johns Hopkins will bill my Health Plan for services to be rendered. However, I also understand that pursuant to Maryland law, Johns Hopkins is authorized to bill me directly under the following conditions:

I. When I choose to receive services covered under my benefit plan without a referral and/or authorization from my Health Plan.

Because I am enrolled in the Health Plan, I must get a signed referral from my primary care physician and/or authorization from my Health Plan to receive covered services. If my Health Plan determines that I did not get a referral and/or authorization when I should have, I understand that I am responsible for payment for the services rendered.

II. When I receive services that are not covered under my benefit plan.

If my Health Plan decides that the services I receive are not covered under by benefit policy, I understand that I will be responsible for payment for the services rendered.

III. When I receive services at Johns Hopkins which are covered by my Health Plan but are only reimbursable by the Health Plan if provided by a different provider.

I understand that my Health Plan may choose to "carve out" certain services and require that I receive such services by a particular contracted provider. I further understand that if I am informed at the time of service that Johns Hopkins is not a contracted provider for which reimbursement will be received, yet I choose to go ahead and request the service form Johns Hopkins anyway, that I will be responsible for payment for the "carved-out" service rendered.

My signature below indicates that I understand the above, and, if either of the above scenarios apply, agree to pay for the fees that result from receiving these services.

_____ _____

(Signature) (Date)

_____ _____

(Print Name) (Witness)

On behalf of (if applicable): _____

(Print name of minor or other individual)