Department of Pathology
Box 9203
1 Medical Center Drive
Morgantown, WV 26506
304-293-2092

PATIENT INFORMATION:

Last Name_____ First Name _____Initial_____

Date of Birth_____ Social Security Number _____ Gender____M _____F

Phone_____ Street Address_____

City_____ State_____ Zip Code_____

REFERRING PHYSICIAN:

Physician_____ Phone_____Fax_____

Institution_____ Email_____

Street Address_____

City_____ State_____ Zip Code_____

Additional copies of the report to_____

INSURANCE INFORMATION:

Bill Submitting Institution ☐ Bill Patient ☐

Primary insurance_____ Phone_____

Street Address_____

City_____ State_____ Zip Code _____

Policy holder's name_____ Social Security #_____

ID#_____ Group Name_____ Group Number_____Effective date_____

Secondary insurance_____ Phone_____

Street Address_____

City_____ State_____ Zip Code _____

Policy holder's name_____ Social Security #_____

ID#_____ Group Name_____ Group Number_____ Effective date_____

MEDICARE/MEDICAID:

Medicare Number_____ Effective date_____

Medicaid Number_____ Effective date (from)_____ (to)_____