HARVARD MEDICAL FACULTY PHYSICIANS
AT BETH ISRAEL DEACONESS MEDICAL CENTER, INC.
With our community affiliates
ASSOCIATED PHYSICIANS OF HARVARD MEDICAL FACULTY PHYSICIANS AT BIDMC, INC.

Affiliated with

Beth Israel Deaconess Medical Center

Harvard Medical School

330 Brookline Ave. Boston, MA 02215 | Phone: 617-667-4353 | 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.

There are three options that can be used for making the credit card payment, please choose one (1):

- Log to this secure website, www.peryourhealth.com, and enter the account number **2042-42PREPAY** and Password: **6WPJ7G** Patient's Date of Birth: **07/01/2011**. Choose the Make a Payment option from the menu and enter the credit card information as appropriate.
- By telephone via IVR (interactive voice response) by calling 1-877-247-2143 and using the account number 2042-42PREPAY
- By telephone calling our billing office at 1-800-866-6663 and choosing one of these specialized representatives, who are aware of this arrangement and would be more than happy to assist:
    - Julie ext. 3014
    - Lorrie Beal ext. 3058
    - Amy Collis ext. 3035

Once payment has been 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)

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

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

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**Patient Identification (Name and DOB)