CASTLE
BIOSCIENCES INCORPORATED

3737 N 7th St, Suite 160
Phoenix AZ, 85014
T: (866) 788-9007 F: (866) 712-5207

*REQUIRED FIELDS

UM DECISIONDx

Requisition Form

I. Ordering Clinician Information

Name of Ordering Clinician*

Specialty NPI

Address*

City / State / Zip*

Telephone / Fax*
( ) ( )

Institution / Practice Name*

II. Patient Information

Last Name* First Name* M.I.

DOB* Gender* SSN / Medical Record #*

Address

City / State / Zip

Phone Email
( )

*** Has the tissue in this sample been exposed to radiation?**
☐ **YES** ☐ **NO**

*** DO YOU WANT PRAME REPORTED WITH THIS ORDER?**
☐ **YES** ☐ **NO**

III. Billing Information

Submitting Diagnosis:

ICD-10 Code*

Method of Payment

- ☐ Bill Private Insurance (Include copy of card)
- ☐ Bill Medicare ****Section IV required***
- ☐ Bill Medicaid
- ☐ Patient Self Pay *(Ask about Castle Assistance Program)*
- ☐ Client Bill (contracted entities only)

Primary Insurance Co. Name *(See #3, page 2)*

Insurance Co. Address Policy#

City / State / Zip

Insurance Co. Phone#
( )

Secondary Insurance? ☐ yes ☐ no
(If yes, attach copy of front/back of secondary insurance card)

IV. *Medicare Only* **Required for patients with traditional Medicare as primary insurance*

Type of facility (where tissue was collected): Non-hospital Hospital (or hospital affiliate) Date of discharge *(hospital only)*: ____________

If specimen is stored for <u>more than 30 days</u> from the date of collection, please provide the date specimen is pulled from archive: ____________

V. Required Signature

SIGNATURE OF ORDERING CLINICIAN*
X

Date

Printed Name

The above signature confirms this test to be medically necessary for this patient. This clinician provides consultation and/or treatment for a specific medical condition and will use the results in the management of the patient.

VI. Additional Order Information

Name of Treating Clinician *(if different than above)*

Phone # Fax #
( ) ( )

Mailing Address (☐ same as requestor)

City / State / Zip

Report Delivery Preferences
☐ Mail ☐ Fax ☐ Online secure access

Email address for report notification

Additional Clinician *(optional)*

Phone # Fax #
( ) ( )

Mailing Address (☐ same as requestor)

City / State / Zip

Report Delivery Preferences
☐ Mail ☐ Fax ☐ Online secure access

Email address for report notification

VII. Sample Collection Facility

Type of Specimen being submitted for testing: ☐ Fine Needle Aspiration Biopsy ☐ Slides from Formalin Fixed Paraffin Embedded Tumor Tissue

Name of Facility where tissue is maintained: ____________ *Date of Collection: ____________

Facility Contact Person: ____________ Phone: ____________ Fax: ____________

FOR INTERNAL USE ONLY

Date received: ____________ Processed by: ____________ Materials received: ____________

PR: ____________ DTL: ____________ Note: ____________

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Requisition Form Completion Instructions

The nature of frozen specimens requires close coordination between the ordering clinician and our laboratory. Therefore, if you are a new customer, we request that you call our customer service line (866-788-9007, option 1) and email the Director of Clinical Services **(tpoteet@castlebiosciences.com)** ***so we can coordinate the process prior to placement of an order.***

1. **Section I**: Complete with information of the ordering physician.

2. **Section II**: Complete with patient information
   *A patient social security number OR medical record number **must** be provided.

3. **Section III**: Provide the patient's diagnosis and billing information including a copy of the front and back of the insurance card (if applicable). If the person completing this requisition is not in possession of the information necessary for completion of the billing information section, please provide the name/department and contact information of the appropriate party from whom this information can be obtained:
   Name: ______________________ Department: _____________________
   Phone: ______________________ Fax: _______________________
   (*if a copy of the front and back of the insurance card is provided, no further information is needed in this section of the requisition)

4. **Section IV**: Applicable only for patients with Traditional Medicare as their primary insurance.

5. **Section V**: The ordering physician must sign this section. **For purposes of ordering this test, the "ordering physician" section can be signed only by a physician, advanced practice registered nurse (APRN) or representative Physician's Assistant (PA)**

6. **Section VI:** Complete with information for the treating physician. If the mailing address is the same as for the ordering physician, check the box "same as requestor". Be sure to select the preferred method by which results should be communicated and provide an email address if you wish to receive electronic notification that the report is available.

   If you would like to have Castle Biosciences provide results to a collaborating physician, please provide that physician's information in the area marked "ADD'L Physician" and a copy of the report will be provided to that individual.

7. **Section VII:** This section is **required**. Complete with the type of specimen being submitted for testing, the name of the facility where the procedure is performed and the specimen collection date.

FAX THE FOLLOWING DOCUMENTS TOLL FREE AT 1-866-712-5207

- ☐ Completed requisition
- ☐ Pathology report *(for FFPE specimens only)*
- ☐ Signed letter of medical necessity

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