

**Requisition Form**

Fax completed form to: 866-329-2224  
Alternate fax: 602-266-9597

*\*Required fields*

**I. Ordering Entity Information**

**II. Patient Information**

**III. Billing Information**

Name of Ordering Provider*		Last Name*	First Name*	MI	Submitting Diagnosis	ICD-10 Code*
Specialty	NPI	DOB*	Gender	SSN / MR#	Method of Payment:	
Address*		Address*			<input type="checkbox"/> Private Insurance <input type="checkbox"/> Patient Self-Pay <input type="checkbox"/> Medicare <i>*Section IV required</i> <input type="checkbox"/> Medicaid <input type="checkbox"/> Client Bill (contracted entities only)	
City / State / Zip*		City / State / Zip*			Primary Insurance Co. Name	Policy#
( ) ( ) Telephone*	( ) ( ) Fax*	( ) ( ) Telephone*			( ) ( ) Insurance Co. Phone#	
Institution / Practice Name*		Email			<b>Secondary Insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach copy of front/back of secondary insurance card)	

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

At time of tissue collection, was this patient:     Non-hospital     Hospital Outpatient     Hospital Inpatient    If hospital inpatient, date of discharge: \_\_\_\_\_

If specimen is stored for more than 30 days from the date of collection, please provide the date specimen is pulled from archive: \_\_\_\_\_

**V. Clinical Information\***

Is the malignant potential of this melanocytic lesion uncertain?\*     Yes     No

Does this lesion have spitzoid features?\*     Yes     No    Does this lesion have only a junctional or intraepidermal component?\*     Yes     No

**IMPORTANT TO NOTE:** In instances where myPath Melanoma (23-GEP) has an Intermediate result, DiffDx-Melanoma (35-GEP) will be subsequently performed. These tests are intended for the in vitro analysis of primary cutaneous melanocytic lesions for which malignant potential is uncertain. They cannot be ordered for lesions which are metastatic or non-melanocytic in nature. Further, test performance has not been validated in patients receiving immunosuppressant or radiation therapy.

**VI. Required Signature**

X
SIGNATURE OF ORDERING PROVIDER*
Printed Name
Date
This signature confirms this test to be medically necessary for this patient. This clinician provides consultation and/or treatment for melanocytic lesions and will use the results in the management of the patient.
<input type="checkbox"/> I would like to sign-up for online ordering

**VII. Additional Order Information**

Name of Treating Clinician (if different than section I)	Additional Provider (optional)
( ) ( ) Phone #                      Fax#	( ) ( ) Phone #                      Fax#
Mailing Address ( <input type="checkbox"/> same as requestor)	Mailing Address ( <input type="checkbox"/> same as requestor)
City / State / Zip	City / State / Zip
Institution/Practice Name	Institution/Practice Name
Email address for report notification	Email address for report notification

**VIII. Laboratory Information**

Please fax this requisition along with a copy of the pathology report from the primary biopsy

Facility where tissue is maintained: \_\_\_\_\_ Date of Collection: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**FOR INTERNAL USE ONLY**

Received: \_\_\_\_\_ Processed by: \_\_\_\_\_ Materials received: \_\_\_\_\_

PR/Initials: \_\_\_\_\_ DTL: \_\_\_\_\_ Note: \_\_\_\_\_

**Submit the following forms via the Online Portal at [CastleTestInfo.com](http://CastleTestInfo.com) or  
Fax Toll Free 1-866-329-2224 (Alternate fax: 602-266-9597)  
These forms may also accompany the specimen upon specimen submission.**

- Completed requisition
- Pathology report(s)\*
- Signed letter of medical necessity

\*In the absence of a preliminary path report, please submit the following form, or other document containing the following information:

- Pathologist \_\_\_\_\_
- Pathology lab \_\_\_\_\_
- Accession#/Specimen ID \_\_\_\_\_
- Date of collection \_\_\_\_\_
- Tumor site \_\_\_\_\_
- Working differential/differential diagnoses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Order confirmation will be sent to the ordering clinician via fax within 24 hours of receipt

## Requisition Form Completion Instructions

- Section I:** Complete with information of the ordering Entity.
- Section II:** Complete with patient information.
- Section III:** Provide the ICD-10 code and patient's diagnosis. Select Method of Payment. Please complete with 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. A billing face sheet is also sufficient, in lieu of copy of card.

- Section IV:** Applicable only for patients with Medicare as their primary insurance.
- Section V:** Check the appropriate box confirming unknown malignant potential. Please also indicate if the specimen being submitted has spitzoid features and/or if the lesion has only a junctional or intraepidermal component.
- Section VI:** The ordering provider must sign this section. \*\*For purposes of ordering this test, the "ordering provider" section can be signed by a physician, advanced practice registered nurse (APRN) or representative Physician Assistant (PA)\*\* **Please check the box if you would like access to online ordering.**
- Section VII:** Complete with information for the treating clinician and/or additional clinicians. If the mailing address is the same as for the ordering provider, 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.
- Section VIII:** Complete this section with the name of the facility where the tissue from which slides for testing will be requested. Provide the name and phone # of an individual to whom a tissue request should be made.