CASTLE BIOSCIENCES INCORPORATED
3737 N. 7th Street, Suite 160
Phoenix AZ, 85014
T: (866)788-9007 F: (866)712-5207

MELANOMA 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

III. Billing Information

Submitting Diagnosis:

ICD-10 Code*
Please Select Code From Drop Down List

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 more than 30 days 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. Laboratory information

Associated pathology report(s) must be submitted with completed requisition

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

Facility Contact Person: Phone: Fax:

*REQUIRED FIELD

FOR INTERNAL USE ONLY

Date received: Processed by: Materials received:

PR: DTL: Note:

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Requisition Form Completion Instructions

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

2. **Section II**: Complete with patient information

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 clinician must sign this section. **For purposes of ordering this test, the "ordering clinician" 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 clinician. If the mailing address is the same as for the ordering clinician, 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 clinician, please provide that clinician's information in the area marked "Additional Clinician" and a copy of the report will be provided to that individual.

7. **Section VII:** Complete this section with the name of the facility where the tissue from which slides for testing will be requested. Provide the date the collection procedure was done, as well as the name and phone # of an individual to whom a tissue request should be made.

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

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