



3330 N 2nd Street, Suite 501
Phoenix, AZ 85012

Requisition Form

I. Ordering Physician Information

Name of Ordering Physician _____

Address _____

City/ State/Zipcode _____

Telephone / Fax
() / () _____

Institution / Practice name _____

II. Patient Information

Last Name _____ First name _____ M.I _____

DOB _____ Gender _____ SSN# _____ Medical Record # _____

Address _____

City _____ State _____ Zipcode _____

Phone _____ email _____
()

III. Billing Information

Submitting Diagnosis: _____
 ICD-9 Code _____
 Method of Payment
 Bill private insurance
 Bill Medicare
 Bill Medicaid
 Patient self pay
 Client Bill

Medicare Only: _____
 Hospital inpatient
 Recently resected GBM
 Date of hosp dc (post-op): _____

Attach copy of front and back of insurance card
 (if provided, no further info needed)

Relationship to insured _____

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

Insurance Co. Address _____

City _____ State _____ Zipcode _____

Insurance Co Phone # _____
()

Secondary Insurance? yes no
 (If yes, attach copy of front/back of secondary ins. Card)

IV. Required Signature

V. Order Information

SIGNATURE OF ORDERING PHYSICIAN

X _____

Date _____

Printed Name _____

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

TREATING PHYSICIAN _____ NPI _____	ADD'L PHYSICIAN (optional) _____ NPI _____
Phone # _____ Fax# _____ () ()	Phone # _____ Fax# _____ () ()
Specialty <input type="checkbox"/> surgery <input type="checkbox"/> oncology <input type="checkbox"/> other _____	Specialty <input type="checkbox"/> surgery <input type="checkbox"/> oncology <input type="checkbox"/> other _____
Overnight mail address (<input type="checkbox"/> Same as requestor)	Overnight mail address (<input type="checkbox"/> Same as account)
City / State / Zip _____	City / State / Zip _____
Report Delivery Preferences <input type="checkbox"/> overnight mail <input type="checkbox"/> fax <input type="checkbox"/> online secure access	Report Delivery Preferences <input type="checkbox"/> overnight mail <input type="checkbox"/> fax <input type="checkbox"/> online secure access
Email address for report notification _____	Email address for report notification _____

VI. Tissue Sample Location

NAME OF LABORATORY WHERE TUMOR TISSUE IS MAINTAINED:

Submitting Pathologist _____	NPI _____	Date of surgery _____	Date block pulled from Archive _____	specimen ID # _____
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Mailing address (of submitting lab) _____ City _____ State _____ Zip _____

Phone: _____ fax: _____
() ()

SHIPPING INVENTORY- DIAGNOSTIC SPECIMEN, NOT RESTRICTED, PACKED COMPLIANCE WITH IATA 650 PACKING MANDATES
 CUSTOMER SERVICE: 866-788-9007

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Requisition Form Completion instructions:

1. **Section I:** Complete with information of the ordering physician.
2. **Section II:** Complete with patient information
3. **Section III:** Provide the billing information for the patient 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:** The ordering physician must sign this section.
5. **Section V:** 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.

6. **Section VI:** Complete this section with the name and address of the laboratory from where tumor tissue will be supplied. If complete information is not known, these areas can be left blank. However, a minimum of the Laboratory name and city must be provided.

FAX THE COMPLETED REQUISITION AND ADDITIONAL DOCUMENTS (AS APPLICABLE) TO CASTLE BIOSCIENCES TOLL FREE AT 1-866-712-5207