CASTLE BIOSCIENCES INCORPORATED.
3330 N 2nd Street, Suite 501
Phoenix AZ, 85012

UM DECISIONDx

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
- ☐ 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 Policy #

City State Zipcode

Insurance Co Phone #
(____)_____

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

IV. Required Signature

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.

V. Order Information

TREATING PHYSICIAN NPI

Phone # Fax#
(_____)_____(_____)_____

Specialty
☐ surgery ☐oncology ☐other _____

Overnight mail address (☐ Same as requestor)

City / State / Zip

Report Delivery Preferences
☐ overnight mail ☐ fax ☐online secure access

Email address for report notification

ADD'L PHYSICIAN (optional) NPI

Phone # Fax#
(_____)_____(_____)_____

Specialty
☐ surgery ☐oncology ☐other _____

Overnight mail address(☐ Same as account)

City / State / Zip

Report Delivery Preferences
☐ overnight mail ☐ fax ☐online secure access

Email address for report notification

VI. Sample Collection Facility

Name of Facility where procedure will be performed: _____ Date of Procedure:_____

Facility Contact Person: Name: _____ Phone: _____ fax: _____

Mailing address City State Zip

If specimen stored for more than 30 days from collection, please provide date specimen is pulled from archive: _____/_____/_____
Mon Day Yr

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

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

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 mailing address of the facility where the procedure will be performed. Provide the date the procedure is to be done, as well as the name and phone # of an individual to whom collection kit materials should be sent.

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

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