



3330 N. 2nd St., Ste 501  
 Phoenix, AZ 85012  
 Ph:(866) 788-9007



Low-grade Glioma

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 \_\_\_\_\_ 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**

**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 \_\_\_\_\_ Specialty \_\_\_\_\_  
 surgery  oncology  other \_\_\_\_\_  surgery  oncology  other \_\_\_\_\_  
 Overnight mail address (  Same as requestor ) \_\_\_\_\_ Overnight mail address (  Same as account ) \_\_\_\_\_  
 City / State / Zip \_\_\_\_\_ City / State / Zip \_\_\_\_\_  
 Report Delivery Preferences \_\_\_\_\_ Report Delivery Preferences \_\_\_\_\_  
 overnight mail  fax  online secure access  overnight mail  fax  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 # \_\_\_\_\_  
 Mailing address (of submitting lab) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone: \_\_\_\_\_ fax: \_\_\_\_\_  
 (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

SHIPPING INVENTORY- DIAGNOSTIC SPECIMEN, NOT RESTRICTED, PACKED IN COMPLIANCE WITH IATA 650 PACKING MANDATES  
 CUSTOMER SERVICE: 866-788-9007 **©Castle Biosciences, Inc. 2010**



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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**