



3330 N 2nd Street, Suite 207  
 Phoenix AZ, 85012  
 P: (866) 788-9007 F: (866) 712-5207

## Requisition Form

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### I. Ordering Physician Information

Name of Ordering Physician \_\_\_\_\_

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-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 / Zip \_\_\_\_\_

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 _____	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 _____
Mailing Address ( same as requestor) _____	Mailing Address ( same as requestor) _____
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. Sample Collection Facility

Name of Facility where procedure will be performed: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_

Facility Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If Specimen is stored for more than 30 days from collection, please provide date specimen is pulled from Archive: \_\_\_\_\_

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

*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](mailto:koelschlager@castlebiosciences.com)) so we can coordinate the process prior to placement of an order.*

**Requisition Form Completion instructions:**

- Section I:** Complete with information of the ordering physician.
- Section II:** Complete with patient information
- 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)
- Section IV:** The ordering physician must sign this section.
- 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.

- 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**