CASTLE BIOSCIENCES

Fax completed form to: (878) 213-3022

TissueCypher ▸ Barrett's Esophagus

TissueCypher Requisition Form

**Required field*

I. ORDERING ENTITY INFORMATION

Provider Name*	Specialty	NPI	Practice Name*
Address*			City/State/Zip*
Office Contact Name	Phone*	Fax *	Email

II. PATIENT INFORMATION

Name (last, first, MI)*	Gender*	DOB*	MRN
Address* *(may be attached separately)*			City/State/Zip*
Phone	E-mail		

III. BILLING INFORMATION

Submitting Diagnosis / ICD-10 Code	Method of payment ☐ Private Insurance ☐ Patient Self-Pay ☐ Medicare ☐ Medicaid ☐ Client Bill
Insurance name* *(may be attached separately)*	Insurance Phone / Policy #*

Medicare Only

At the time of collection, was this patient: ☐ Non-hospital ☐ Hospital Outpatient ☐ Hospital Inpatient; date of discharge: _____

If specimen stored for > 30 days from date of collection, provide the date specimen is pulled from archive: _____

IV. REQUIRED SIGNATURE FOR ORDERING TISSUECYPHER

Signature of Clinician*	Printed Name	Date

This signature confirms this test to be medically necessary for this patient. This clinician provides consultation and/or treatment for the diagnosis and will use the results in the management of the patient.

V. ADDITIONAL ORDER INFORMATION

Treating Provider Name *(if different than section I)*	Practice Name	Phone/Fax
Address ☐ same as requestor		City/State/Zip

VI. LABORATORY INFORMATION

Pathology Lab Name	Date of Collection
Phone	Fax

Please fax this requisition along with a copy of the pathology report and endoscopy report *(if available)*

FOR INTERNAL USE ONLY

Received: _____ Processed by: _____ Materials received: _____

PR/Initials: _____ DTL: _____ Note: _____

Requisition Form Completion Instructions

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

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

3. **Section III**: Provide the ICD-10 code and patient's diagnosis. Select Method of Payment. Please complete with billing information OR include a copy of the billing face sheet or 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: _____

   *Medicare only section is required for patients with Traditional Medicare.

4. **Section IV:** 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 Assistant (PA)**

5. **Section V:** Complete with information for the treating clinician and/or additional clinicians. 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.

6. **Section VI:** Complete this section with the name of the facility and contact information where the tissue from which slides for testing will be requested.

FAX THE FOLLOWING DOCUMENTS TOLL FREE AT (878) 213-3022

*Order confirmation will be sent to the ordering clinician via fax within 24 hours of receipt

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