CASTLE BIOSCIENCES

TissueCypher
Barrett's Esophagus

Customer service: **412-820-3050**
Email: **clinicalservices@castlebiosciences.com**
Fax toll free: **878-213-3022**

Please fax this requisition along with a copy of the pathology report, endoscopy report, and face/demographic sheet

I. Ordering entity information

Provider name*	Specialty	NPI	Institution / Practice name*
Address*		City / state / zip*	
Office contact name	Phone*	Fax*	Email

II. Patient information

Name (last, first, MI)*	Gender*	DOB*	MR#
Address* (may be attached seperately)		City / state / zip*	
Phone		Email	

III. Billing information

Submitting diagnosis / ICD-10 code*

☐ K22.70 Barrett's esophagus without dysplasia

☐ K22.710 Barrett's esophagus with low grade dysplasia

☐ K22.719 Barrett's esophagus with dysplasia, unspecified

Payment method ☐ Private insurance ☐ Patient self-pay ☐ Medicare ☐ Medicaid ☐ Client bill *(contracted entities only)*

Insurance name* (may be attached seperately)	Policy #*	Insurance phone

IV. Facility information

At time of tissue collection, was this patient:* ☐ Non-hospital ☐ Hospital outpatient ☐ Hospital inpatient, date of discharge _____

If specimen is stored **for more than 30 days** from the date of collection, please provide the date specimen is pulled from archive: _____

V. Required signature

This signature confirms the TissueCypher Barrett's Esophagus 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.

Signature of treating clinician*	Printed name	Date

VI. Treating clinician

Treating provider name *(if different than section I)*	Phone	Fax	Institution / Practice name
Address (☐ same as requestor)		City / state / zip	

VII. Laboratory information

Pathology laboratory name	Date of collection
Phone	Fax

For internal use only

Received	Processed by	Materials received
PR / Initials	DTL	Note

* Required item

Customer service: **412-820-3050** | Email: **clinicalservices@castlebiosciences.com**
Fax toll free: **878-213-3022**

TissueCypher
▸ Barrett's Esophagus

SECTION I. Complete with information of the ordering entity.

SECTION II. Complete with patient information.

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: _____

SECTION IV. Complete with facility information.

SECTION V. 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)**

SECTION VI. Complete with information for the treating clinician. If the mailing address is the same as for the ordering clinician, check the box "same as requestor".

SECTION VII. Complete this section with the name and contact information for the facility from which the tissue block(s) or slides for testing can be requested.

Fax the following documents toll free: **878-213-3022**
or securely email **clinicalservices@castlebiosciences.com**

- ☐ Completed requisition
- ☐ Pathology report(s)
- ☐ Endoscopy report(s)
- ☐ Face/demographic sheet (optional)

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

If you are interested in online ordering, please contact us at
clinicalservices@castlebiosciences.com

CASTLE BIOSCIENCES
100 S. Commons Suite 245
Pittsburgh, PA 15212
castlebiosciences.com