CASTLE BIOSCIENCES

3737 N 7th Street, Suite 160
Phoenix, AZ 85014
Customer Service: 866-788-9007

DecisionDx DiffDx-Melanoma

Requisition Form

**Required fields*

I. Ordering Entity Information

Name of Ordering Provider*

Specialty NPI

Address*

City / State / Zip*

( ) ( )
Telephone* Fax*

Institution / Practice Name*

II. Patient Information

Last Name* First Name* MI

DOB* Gender SSN / MR#

Address*

City / State / Zip*

( )
Telephone*

Email

III. Billing Information

Please Select Code From Drop Down List
Submitting Diagnosis ICD-10 Code*

Method of Payment:
☐ Private Insurance ☐ Patient Self-Pay
☐ Medicare ***Section IV required*** ☐ Medicaid
☐ Client Bill *(contracted entities only)*

Primary Insurance Co. Name Policy#

( )
Insurance Co. Phone#

Secondary Insurance? ☐ Yes ☐ No
(If yes, attach copy of front/back of secondary insurance card)

IV. Medicare Only* *(Required for patients with traditional Medicare as primary insurance)*

At time of tissue collection, was this patient: ☐ Non-hospital ☐ Hospital Outpatient ☐ Hospital Inpatient If 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. Clinical Information

Is the malignant potential of this melanocytic lesion uncertain?* ☐ Yes ☐ No

IMPORTANT TO NOTE*: This test is intended for the in vitro analysis of primary cutaneous melanocytic lesions for which malignant potential is uncertain. It should not be ordered for lesions which are metastatic or non-melanocytic in nature. Further, test performance has not been validated in patients receiving immunosuppressant or radiation therapy.*

VI. Required Signature

X

SIGNATURE OF ORDERING PROVIDER*

Printed Name

Date

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

☐ **I would like to sign-up for online ordering**

VII. Additional Order Information

Name of Treating Clinician *(if different than section I)*

( ) ( )
Phone # Fax#

Mailing Address (☐ same as requestor)

City / State / Zip

Institution/Practice Name

Email address for report notification

Additional Provider *(optional)*

( ) ( )
Phone # Fax#

Mailing Address (☐ same as requestor)

City / State / Zip

Institution/Practice Name

Email address for report notification

VIII. Laboratory Information

Please fax this requisition along with a copy of the pathology report from the *primary* biopsy

Facility where tissue is maintained: _____ Date of Collection: _____

Phone: _____ Fax: _____

FOR INTERNAL USE ONLY

Received: _____ Processed by: _____ Materials received: _____

PR/Initials: _____ DTL: _____ Note: _____

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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 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. A billing face sheet is also sufficient, in lieu of copy of card.

4. **Section IV**: Applicable only for patients with Medicare as their primary insurance.

5. **Section V**: Check the appropriate box confirming unknown malignant potential

6. **Section VI:** The ordering provider must sign this section. ****For purposes of ordering this test, the "ordering provider" section can be signed by a physician, advanced practice registered nurse (APRN) or representative Physician Assistant (PA)**** **Please check the box if you would like access to online ordering.**

7. **Section VII:** Complete with information for the treating clinician and/or additional clinicians. If the mailing address is the same as for the ordering provider, 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.

8. **Section VIII:** Complete this section with the name of the facility where the tissue from which slides for testing will be requested. Provide the name and phone # of an individual to whom a tissue request should be made.

FAX THE FOLLOWING DOCUMENTS TOLL FREE AT 1-866-329-2224
(Alternate fax: 602-222-5200)

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

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