TissueCypher
► Barrett's Esophagus

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

Customer service: **866-788-9007**
Email: **clinicalservices@castlebiosciences.com**
Fax toll free: **866-329-2224**

I. Ordering entity information

Provider name*	NPI	Institution / Practice name*	
Address*	City / state / zip*		Specialty
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

Required for all patients*

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: _____

IV. Required signature

This signature confirms the test to be medically necessary for this patient. This clinician provides consultation and/or treatment for Barrett's esophagus and will use results in the management of the patient. This clinician further acknowledges that any information derived from Castle Biosciences testing will not be used for research or test development without providing prior written notice to Castle Biosciences and receiving written acknowledgment in response. Any unauthorized uses may be prohibited by applicable law, including the laws and regulations implemented by the U.S. Food and Drug Administration.

Signature of treating clinician*	Printed name*	Date*

V. Additional order information

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

VI. Laboratory information

Pathology laboratory name	Date of collection*
Phone	Fax

INTERNAL USE ONLY

* Required item

100 S. Commons Suite 245 | Pittsburgh, PA 15212

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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: _____

**This section is required for all patients.*

SECTION IV. The treating clinician must sign this section. ***For purposes of ordering this test, the "treating clinician" section can be signed only by a physician, advanced practice registered nurse (APRN) or representative Physician Assistant (PA)***

SECTION V. Complete with information for the treating clinician and/or additional clinicians. If the mailing address is the same as for the treating 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.

SECTION VI. 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: **866-329-2224**
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
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