

**Shipping Address**

**Specimen drop-off locations:**

**Internal use only**

**WashU Medicine**  
 Department of Pathology & Immunology,  
 Clinical Support Office  
 425 S. Euclid Ave | MSC 8024-14-4711  
 St. Louis, MO 63110  
 Phone: 314-747-1100 | Fax: 314-362-4080

**WashU Medicine**  
 Department of Pathology & Immunology,  
 Clinical Support Office  
 509 S. Euclid Ave | West Building | Suite 4711  
 St. Louis, MO 63110  
 Phone: 314-747-1100

**This requisition has two pages, please complete both pages to ensure testing.**

PATIENT IDENTIFICATION				PHYSICIAN ORDERING TEST <i>(NPI required)</i>			
Patient Status: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Office Visit				Name:			
Name Last:		First:		MI:		Institution:	
DOB (mm/dd/yyyy):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		NPI:		Email:	
Medical Record # (if applicable):				Address:			
Address:				City:		State:	Zip:
City:		State:		Zip:		Phone:	
City:		State:		Zip:		Fax:	
Ethnicity (select all that apply)				Alternative Contact Information:			
<input type="checkbox"/> African American		<input type="checkbox"/> Asian		<input type="checkbox"/> Caucasian/NW European		Phone:	
<input type="checkbox"/> E Indian		<input type="checkbox"/> Hispanic		<input type="checkbox"/> Jewish-Ashkenazi		Email:	
<input type="checkbox"/> Mediterranean		<input type="checkbox"/> Native Hawaiian/Pacific Islander		<input type="checkbox"/> Other		Notes:	

SPECIMEN INFORMATION				
Specimen type (select one):	<input type="checkbox"/> FNA smear	<input type="checkbox"/> Archival tissue	External case #:	Tumor origin, please specify:
Date & Time of Specimen Collection:				

**SPECIMEN REQUIREMENTS**

Please submit formalin-fixed, paraffin-embedded (FFPE) tissue block or alcohol-fixed, paraffin-embedded cell block, or 10 unstained unbaked slides at 10µm thickness, and 1 marked H&E. Minimum tumor cellularity: 5%.

CLINICAL INFORMATION			
Diagnosis/Clinical history:			
ICD10 Code(s):			
Disease status:	<input type="checkbox"/> New diagnosis:	<input type="checkbox"/> Metastasis:	<input type="checkbox"/> Recurrence:

TESTING REQUESTED
<input type="checkbox"/> <b>GatewaySeq NGS Panel with Interpretation</b>
GatewaySeq W case number label (internal use only)

**Healthcare Professional Signature to Authorize Testing and Statement of Medical Necessity**  
 I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

Signature:	Date:
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**PATIENT INFORMATION**

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):
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**BILLING INFORMATION  
(CHECK ONE)**
 **Bill Patient/Insurance-Complete Section A**
 **Bill Submitting Institution-Complete Section B**
**SECTION A-PATIENT/INSURANCE BILLING INFORMATION**

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. For MEDICAID patients, Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered services. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at (314) 362-5641 or via email at [path-billing@email.wustl.edu](mailto:path-billing@email.wustl.edu) for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):
CPT Codes and Unit Authorized:	

**ATTACH COPY OF INSURANCE CARD (if not available, complete the following)**

Policy Holder's Name			Insurance Co. Name:	
Last:	First:	MI:	Insurance Co. Phone:	
Policy Holder's Date of Birth (mm/dd/yyyy):			Plan Name:	
Relationship to Patient:			ID#:	Group#:

**SECTION B-INSTITUTIONAL BILLING**

Institution Name:				
Contact Name:			PO Number (if applicable):	
Email:				
Accounts Payable Billing Address:				
City:		State:		ZIP:
Phone:		Fax:		