

Shipping Address

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

Specimen drop-off locations:

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

Internal use only

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

PATIENT IDENTIFICATION
PHYSICIAN ORDERING TEST *(NPI required)*

Patient Status: ☐ Inpatient ☐ Outpatient ☐ Office Visit				Name:	
Name Last:	First:	MI:	Institution:		
DOB (mm/dd/yyyy):	Sex: ☐ Male ☐ Female	NPI:		Email:	
Medical Record # (if applicable):			Address:		
Address:			City:	State:	Zip:
City:	State:	Zip:	Phone:	Fax:	
Ethnicity (select all that apply)			Alternative Contact Information:		
☐ African American ☐ Asian ☐ Caucasian/NW European ☐ E Indian ☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic ☐ Mediterranean ☐ Native Hawaiian/Pacific Islander ☐ Other			Phone:	Email:	
			Notes:		

SPECIMEN INFORMATION

Specimen type (select one):	☐ FNA smear	☐ 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:	☐ New diagnosis:	☐ Metastasis:	☐ Recurrence:

TESTING REQUESTED

☐ GatewaySeq NGS Panel with Interpretation
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 for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):
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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:		