Washington University Physicians®

# Heme Molecular Testing

**Shipping Address**

Washington University School of Medicine
Department of Pathology & Immunology,
Clinical Support Office
425 S. Euclid Ave; Campus Box 8024
Saint Louis, MO 63110
Phone: 314-747-1100 | Fax: 314-362-4080

**Specimen drop-off locations:**

Washington University School of Medicine
Department of Pathology & Immunology,
Accessioning Hemepath Bench
425 S. Euclid Ave, Rm 3702
Saint Louis, MO 63110
Phone: 314-747-1100

Washington University School of Medicine
Department of Pathology & Immunology,
Clinical Support Office
509 S. Euclid Ave, West Building, Suite 4711
Saint Louis, MO 63110
Phone: 314-747-1100

***Internal Use Only***

**This requisition has two pages, please be sure to accurately complete both.**

| **PHYSICIAN ORDERING TEST** *(NPI required)* | | | **PATIENT IDENTIFICATION** | | |
|---|---|---|---|---|---|
| Name: | | | Name Last: | First: | MI: |
| NPI: | Email: | | DOB (mm/dd/yyyy): | Gender: ☐ Male ☐ Female | |
| Phone: | Fax: | | Medical Record # (if applicable): | | |
| Pager: | | | | | |
| Address: | | | Address: | | |
| City: | State: | Zip: | City: | State: | Zip: |

## SPECIMEN INFORMATION

Specimen type (select one): ☐ Bone Marrow ☐ Peripheral Blood ☐ Other (requires pre-approval):

Date & Time of Specimen Collection:

## SPECIMEN REQUIREMENTS

Bone marrow pink top (EDTA) 0.5ml or Peripheral blood lavender top (EDTA) 0.5ml.

## CLINICAL INFORMATION

Diagnosis (please indicate AML, MDS or MPN):

ICD10 Code(s):

Disease status: ☐ New diagnosis ☐ Relapse ☐ Remission

## TESTING REQUESTED

| ☐ **MyeloSeq™ 40 Gene Heme Sequencing Panel with Interpretation** | ☐ **ChromoSeq Whole Genome Sequencing with Interpretation*** <br> ** All ChromoSeq orders must be approved by the Section of Molecular Oncology* |
|---|---|
| MyeloSeq W case number label (Internal use only) | **ChromoSeq 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: |
|---|---|

## PATIENT INFORMATION

| Last Name: | First Name: | MI: | DOB (mm/dd/yyyy): |
|---|---|---|---|

## INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at 314-362-5641 or via e-mail at 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 Units Authorized: | | |
| **ATTACH COPY OF INSURANCE CARD (if not available, complete the following)** | | |
| Policy Holder's Name: Last First MI | Insurance Co. Name: | |
| | Insurance Co. Phone: | |
| Policy Holder's Date of Birth (mm/dd/yyyy): | Plan Name: | |
| Relationship to patient: | ID#: | Group#: |

## SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our Patient Accounts Manager office at 314-362-5641 or via e-mail at path-billing@email.wustl.edu.

## AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR ACCOUNT

I authorize the disclosure of insurance benefit coverage and payment information to Washington University School of Medicine. I authorize Washington University School of Medicine to furnish any medical information requested on myself, or my covered dependents. I assign and authorize insurance payments to Washington University School of Medicine. I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if Washington University School of Medicine is not a participant with my health plan, and/or my health plan does not fully reimburse medical services due to lack of authorization or medical necessity.

| | | |
|---|---|---|
| Signature of Patient or Guardian | Printed Name of Patient or Guardian | Date |

**Reference Laboratories: complete section below**

## INSTITUTIONAL BILLING

| Institution Name: | | |
|---|---|---|
| Contact Name: | | |
| Email: | | |
| Billing Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |