

**Shipping Address**

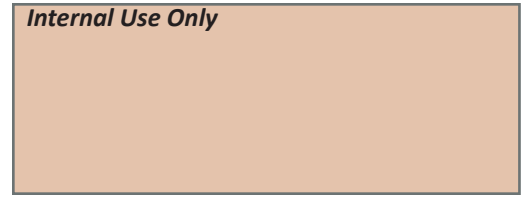
Washington University School of Medicine  
 Department of Pathology & Immunology,  
 Clinical Support Office  
 425 S. Euclid Ave; Campus Box 8024  
 Saint Louis, MO 63110  
 Phone: 314-747-1100 | Fax: 314-362-4080

**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:				
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**

<b>MyeloSeq™ 40 Gene Heme Sequencing Panel with Interpretation</b>	<b>ChromoSeq Whole Genome Sequencing with Interpretation*</b> <small>* All ChromoSeq orders must be approved by the Section of Molecular Oncology</small>
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):
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**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](mailto: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 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](mailto: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
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..... **Reference Laboratories: complete section below** .....

**INSTITUTIONAL BILLING**

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