WashU Medicine

Heme Molecular Testing

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,
Accessioning Hemepath Bench
425 S. Euclid Ave | Rm 3702
St. Louis, MO 63110
Phone: 314-747-1100

WashU Medicine
Department of Pathology & Immunology,
Clinical Support Office
509 S. Euclid Ave | West Bldg | 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

Patient Status: ☐ Inpatient ☐ Outpatient ☐ Office Visit

Name Last: | First: | MI:

DOB (mm/dd/yyyy): | Sex: ☐ Male ☐ Female

Medical Record # (if applicable):

Address:

City: | State: | Zip:

Ethnicity (select all that apply)

☐ African American ☐ Asian ☐ Caucasian/NW European
☐ E Indian ☐ Hispanic ☐ Jewish-Ashkenazi ☐ Jewish-Sephardic
☐ Mediterranean ☐ Native Hawaiian/Pacific Islander ☐ Other

PHYSICIAN ORDERING TEST *(NPI required)*

Name:

Institution:

NPI: | Email:

Address:

City: | State: | Zip:

Phone: | Fax:

Alternative Contact Information:

Phone: | Email:

Notes:

SPECIMEN INFORMATION

Specimen type (select one): ☐ Bone marrow ☐ Peripheral blood ☐ Other (requires pre-approval):

Date & Time of Specimen Collection:

SPECIMEN REQUIREMENTS

1.0 mL peripheral blood or bone marrow aspirate collected in an EDTA tube.

CLINICAL INFORMATION

Diagnosis (please indicate AML, MDS, MPN or B-ALL):

ICD10 Code(s):

Disease status: ☐ New diagnosis: ☐ Relapse: ☐ Remission:

TESTING REQUESTED

MyeloSeq®

☐ Diagnosis MyeloSeq® Heme NGS Panel with Interpretation

☐ Measurable Residual Disease (MRD)
MyeloSeq® Heme NGS Panel with Interpretation

MyeloSeq W case number label (internal use only)

ChromoSeq®

☐ ChromoSeq® Whole Genome Sequencing with Interpretation

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:

WashU Medicine

PATIENT INFORMATION

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

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):
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:	