Washington University Physicians®
Washington University School of Medicine in St. Louis

MyeloSeq™ Heme NGS Panel

Sample drop-off location:

Washington University School of Medicine
Department of Pathology & Immunology, Clinical Support Services Office
509 South Euclid, West Bldg, Rm 3710
Saint Louis, MO 63110
Phone: 314-747-1100 | Fax: 314-362-4080

Office use only
Date/Time Received:
Accession Number:
Technician Initial:

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

Speciman type (select one): ◯ Marrow, Left Iliac ◯ Marrow, Right Iliac ◯ Peripheral Blood

Date & Time of Collection: Tissue Biopsy (please specify):

SPECIMEN REQUIREMENTS

Lavender top EDTA tube. Minimum volume 0.5mL.

CLINICAL INFORMATION

Diagnosis (please indicate AML, MDS or MPN):

ICD10 Code(s):

Disease status: ◯ New diagnosis ◯ Relapse ◯ Remission

Post BMT/SCT: ◯ Autologous ◯ Male donor ◯ Female donor

WBC%: Circulating blasts: Immunophenotype:

TESTING REQUESTED

◯ MyeloSeq™ 40 Gene Heme Sequencing Panel

ADDITIONAL INFORMATION:

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:	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#:

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:	