Washington University in St. Louis
SCHOOL OF MEDICINE

GENOMICS AND PATHOLOGY SERVICES
GPS@WUSTL
CLINICAL TESTING • RESEARCH • EDUCATION

Melanoma Testing Order Form

Please email or fax completed requisition

Note: This form has two pages. Please complete both pages to ensure testing

Physician Ordering Test *(REQUIRED - NPI)*

Name:		
Institution:		
NPI:	Email:	
Address:		
City:	State:	Zip:
Phone:	Fax:	
Alternative Contact Name:		
Phone:	Email:	

Email: gps@wustl.edu **Tel: (314) 747-7337** **Fax: (314) 747-7336**

Sample Shipping Address:
CORTEX Building, 3rd Floor, Suite 302
4320 Forest Park Avenue
St. Louis, MO 63108

BJC Main Campus sample drop off locations:
(internal physicians only)

Children's Hospital
One Children's Place
Central Receiving 2N-25
St. Louis, MO 63110
Tel: (314) 454-6130

North Campus Lab
B101 CAM Building
4940 Parkview Place
St. Louis, MO 63110
Tel: (314) 454-7510

Patient Identification *(REQUIRED - attach relevant patient/family history)*

Patient Status ◯ Inpatient ◯ Outpatient ◯ Office visit

Name Last:	First:	MI:
DOB *(mm/dd/yyyy)*:	Gender ◯ Male ◯ Female	
Medical Record # *(if applicable)*:		
Address:		
City:	State:	Zip:

Ethnicity *(Select all that apply)*

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

Specimen Type

◯ Testing from Archival Specimen(s)

Previous Pathology Case Number:

For samples located outside of BJH submit: (1) Signed Patient Release for Surgical Material Form & (2) Pathology Report

◯ New Specimen(s)

Date Collected *(mm/dd/yyyy)*: Time:

Collected By:

Sample Type *(Select one)*

◯ Formalin Fixed Tissue ◯ Fresh Frozen Tissue ◯ Other:
◯ Bone Marrow Aspirate ◯ Bone Core

Sample Source:

Reason for Testing *(REQUIRED - failure to include a diagnosis may delay testing. Include all pertinent diagnoses and ICD10 codes)*

Diagnosis:

ICD10 Code(s):

Testing Requested

Next-Generation Sequencing

◯ **Melanoma Gene Set** - Next generation sequencing of all coding regions of *AKT1, ALK*, BAP1, BRAF, CDK4, CDKN2A, CTNNB1, EGFR, ERBB2, ERBB4 FGFR1, FGFR2*, FGFR3*, GNA11, GNAQ, HRAS, KIT, KRAS, MAP2K1, MAP2K2, MET, MTOR, NF1, NRAS, PDGFRA, PDGFRB, PIK3CA, PTEN, RAC1, RB1, RET*, ROS1** and *TP53* to detect single nucleotide variants and small insertions and deletions.*selected introns also sequenced to detect rearrangements.

Chromosomal Microarray Testing: please contact us

Additional Information:

Healthcare Professional Signature to Authorize Testing, Statement of Medical Necessity and Transmission of Results Verification

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.

The undersigned Client authorizes the Washington University School of Medicine to send Protected Healthcare Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number above. Client acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.

Signature: Date:

Date/Time Received:	Accession Number:	Technician Initial:

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Please complete all information below. Failure to do so may delay sample processing.

Patient Information

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

Insurance and Precertification

Precertification for all non-government insurance plans is required for genetic testing and will be managed by Genomics and Pathology Services. Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Genomics and Pathology Services (GPS) can only accept authorized and contracted private insurance, Medicare, or Missouri Medicaid programs. Other out-of-state Medicaid programs cannot be billed. Please contact Jean Loehr, Patient Accounts Manager at (314) 362-5641, e-mail: Loehr@wustl.edu, for complete insurance filing information and the managed care/private insurance contract list.

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 DOB:				Plan Name:	
Relationship to Patient:				ID #:	Group #:

Self-Pay and 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 Jean Loehr, Patient Accounts Manager at 314-362-5641, e-mail: Loehr@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 the Section Below

Institutional Billing

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

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Instructions for Completing the Fillable PDF

- Use 'Tab' to move between the fields.
- Complete ALL fields to avoid any delay in processing the requisition.
- Enter phone and fax numbers beginning with area code. Do not enter any characters such as – or /. Upon entering the 10-digit number the form will automatically format. (i.e. 3147477337 will format to (314) 747-7337).
- Enter dates as mm/dd/yyyy. (i.e. 01/05/2001).
- Ordering physician NPI is required.
- Reason for Testing/Diagnosis and ICD9 codes are required in order for us to obtain pre-authorization.

Instructions for Sending the Completed Requisition

- Completed requisitions can be faxed to (314) 747-7336 or mailed with the specimen.
- Alternatively, completed requisitions can be emailed to gps@wustl.edu. For HIPAA compliance, the form either has to be 1) saved as a JPEG or 2) encrypted with a password.

To save form as a JPEG on a PC:

- Have the completed form open with Adobe Reader.
- Select File > Save As > Save as type > JPEG. This way the form cannot be edited.
- Attach the completed requisition to email and send to gps@wustl.edu.

To save form as a JPEG on a Mac:

- Have the completed form open with Preview.
- Select File > Export. Select JPEG and save. This way the form cannot be edited.
- Attach the completed requisition to email and send to gps@wustl.edu.

To encrypt form on a PC:

- Have the completed form open with Adobe Reader.
- Select Secure > Encrypt with Password.
- Compatibility should be Acrobat 7.0 and later
- Select 'Require a password to open the document'.
- Enter password and Confirm password.
- Save and close.
- Attach the completed requisition to email and send to gps@wustl.edu.
- Send additional email with the password.

To encrypt form on a Mac:

- Have the completed form open with Preview.
- Select File > Export. Check Encrypt, enter and verify password.
- Save and close.
- Attach the completed requisition to email and send to gps@wustl.edu.
- Send additional email with the password.

Protected Health Information Transmittal Verification

- To comply with HIPAA regulations, we need to verify that any transmission of PHI data (i.e. clinical report) is being sent securely.
- The undersigned Client authorizes the Washington University School of Medicine to send Protected Healthcare Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number listed on the requisition.
- Client acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.
- **In the event of an erroneous transmission, Client is obligated to immediately notify the sender and to destroy the results.**
- Client may revoke this authorization or change the facsimile number by giving the Washington University School of Medicine Department of Pathology and Immunology either through written or verbal notice with at least 24 hours prior notice.