



Boston Children's Hospital

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PATHOLOGY MOLECULAR TEST REQUISITION

BCH
PATHOLOGY
LABEL

DEPARTMENT OF PATHOLOGY – Farley 190 - BCH3027
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PATIENT INFORMATION: (PLEASE PRINT IN BLACK INK)

LAST NAME		FIRST		MI	
ADDRESS		CITY		STATE	
ZIP		BIRTH DATE		SEX	
PHONE		PATIENT ID #			

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital Discharge Date: ____/____/____

REQUESTOR:	ORDERING PHYSICIAN CONTACT INFORMATION:
NAME	PHYSICIAN NAME
ADDRESS	PHYSICIAN NPI (NON-BCH PROVIDERS)
PHONE	PHYSICIAN PHONE
	PHYSICIAN EMAIL
	CC PROVIDER: _____

REQUESTOR SIGNATURE	TODAY'S DATE ____/____/____
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A prior insurance authorization may be required. Denied claims for any reason will be billed to the requestor.

ICD-10 Diagnosis Code Required: 1. _____ 2. _____ 3. _____

TEST AND SPECIMEN INFORMATION:

☐ Solid and brain tumor fusion panel ☐ Heme malignancy fusion panel ☐ GeneVa Panel ☐ BRAF V600E ddPCR
☐ BrightSEQ Beacon ☐ PIK3CA ddPCR (*select variants*): ☐ C420R ☐ E542K ☐ E545K ☐ H1047L ☐ H1047R ☐ All
☐ MYOD1 L122R ddPCR ☐ Nucleic acid extraction only (*specify type*): ☐ DNA ☐ RNA ☐ TNA

***Procedures include Professional Interpretation unless otherwise requested.** ☐ No Professional Interpretation

Sample Origin: ☐ Bone marrow ☐ Blood ☐ Tissue (Type: _____)

Sample Prep: ☐ Fresh ☐ Frozen ☐ Air dried ☐ Paraffin (FFPE)

Estimate of % tumor cellularity: _____

Collection Date: ____/____/____ Time: _____

CLINICAL INFORMATION:

BRIEF CLINICAL HISTORY

BILL TO: ☐ Patient Insurance ☐ Requestor ☐ Patient Self-Pay **HMO Insurance Authorization #** _____

Charges for patients classified as a hospital "inpatient or "outpatient" at the requesting facility on the date of service must be billed to the requesting facility unless an appropriate exception applies. SSA §1833(h)(5)(A); SSA §1833(h)(5)(A)(iii); SSA §1861(w)(1); 42 §CFR 414.510

INSURANCE NAME

SUBSCRIBER LAST NAME		FIRST		MI		INSURANCE PHONE		BENEFICIARY/MEMBER #	
CLAIMS ADDRESS (IF AVAILABLE)		CITY		STATE		ZIP		GROUP # (IF AVAILABLE)	