TEST REQUISITION FORM

Return with specimen
or by fax: **(858) 258-5188**

Questions,
contact us at: **(858) 886-7907 option 1**

merlinmelanomatest.com/us

1. Healthcare Provider Information

Name		NPI
Institution/Practice Name		
Address		
City	State	Zip Code
Email	Phone	Fax

2. Patient Information

Name		
DOB (mm/dd/yyyy)	Sex	Patient Age at Biopsy
Address		
City	State	Zip Code
MRN	Phone	

3. Specimen Information (Required: 50 µm of FFPE Material)

Biopsy Type ☐ Punch ☐ Shave ☐ Excisional

Case No.	Date of Primary Biopsy (mm/dd/yyyy)
Breslow Thickness (in mm)	Ulceration Status ☐ Yes ☐ No ☐ Unknown

FFPE Specimen Submission Type (select one):
- ☐ Curls in tube (5 x 10 µm)
- ☐ Unstained, unbaked curls on glass slides (5 x 10 µm)
- ☐ FFPE Block (≥50 µm)

Specimen Confirmed to Contain Neoplastic Cells
- ☐ Yes (Attach pathology report)

Select Tumor Staging (AJCC 8th Edition):
- ☐ pT1a (Requires at least one high risk feature)
  - ☐ Patient Age at Biopsy < 40 years old
  - ☐ Mitotic rate ≥2/mm²
  - ☐ Presence of Lymphovascular Invasion
- ☐ pT1b
- ☐ pT2
- ☐ pT3

4. Pathologist Contact

Facility		
Address		
City	State	Zip Code
Phone	Fax	
Contact Name/Dept	Email	

5. Insurance Coding

ICD-10 Codes ______________________________

Additional/Other (please list codes) ______________________________

6. Billing Information

Bill to: ☐ Insurance ☐ Medicare ☐ Client ☐ Self Pay ______________________

Primary Insurance	Policy #	Group #
Primary Policy Holder		DOB (mm/dd/yyyy)
Secondary Insurance	Policy #	Group #

Patient Status if Medicare ☐ Office (Non-hospital) ☐ Outpatient ☐ Inpatient (Discharge date: ______________________)

7. Treating Health Care Provider's Authorization to Perform Test

By signing this form, I confirm that the patient has not undergone a sentinel lymph node biopsy prior to submission for the test.

I authorize the Merlin™ test to be performed, that the test is medically necessary, and that I will use the test results to provide consultation and/or inform treatment decisions for this patient. I hereby attest that I am authorized by law to order the test.

____

Healthcare Provider Signature Date

____

Printed Name

For SkylineDx Internal Use Only

Accession ID	
Date of Specimen Receipt (mm/dd/yyyy)	
Time of Specimen Receipt	☐ AM ☐ PM
Receiver Initials	

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