

TEST REQUISITION FORM



Return with specimen
or by fax: (858) 258-5188
Questions,
contact us at: (858) 886-7907
merlinmelanomatest.com/us

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

Patient Information		
Name		
DOB (mm/dd/yyyy)	Sex ☐ M ☐ F	Patient Age at Biopsy
Address		
City	State	Zip Code
Phone		

Specimen Information (Required: 50 µm of FFPE Material)	
Biopsy Type ☐ Punch ☐ Shave ☐ Excisional	
Specimen ID	
Case No.	Date of Primary Biopsy (mm/dd/yyyy)
Breslow Thickness (in mm)	Ulceration Present ☐ Yes ☐ No
FFPE Specimen Submission Type (select one): ☐ Curls in tube (5 x 10 µm) ☐ Unstained, unbaked sections on glass slides (5 x 10 µm) ☐ FFPE Block (≥50 µm)	
Specimen Confirmed to Contain Neoplastic Melanoma Cells ☐ Yes	
☐ Pathology report(s) attached	

Pathologist Contact ☐ Same as Treating Provider		
Facility		
Address		
City	State	Zip Code
Phone	Fax	
Contact Name/Dept	Email	

Insurance Coding
ICD-10 Codes
Additional/Other (please list codes) _____

Clinical Information
If T1a, are adverse features present? ☐ Yes ☐ No
If Yes, check all that apply: ☐ lymphovascular invasion ☐ age ≤42 years ☐ mitotic rate ≥ 2/mm² ☐ head/neck
Has an SLNB been performed? ☐ Yes ☐ No
If yes, what was the result? ☐ Positive ☐ Negative
If positive, was low tumor burden present in the SLN (<0.1 mm)? ☐ Yes ☐ No

Treating Provider's Authorization to Perform Test	
I authorize the Merlin™ test to be performed, that the provided specimen contains neoplastic melanoma cells, 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.	
Treating Provider Signature	Date
Printed Name	

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: _____)		

For SkylineDx Internal Use Only	
Accession ID	
Date of Specimen Receipt (mm/dd/yyyy)	
Time of Specimen Receipt	☐ AM ☐ PM
Receiver Initials	

TEST REQUISITION FORM



ICD-10 Codes

- C43.0 Malignant melanoma of lip
- C43.10 Malignant melanoma of unspecified eyelid, including canthus
- C43.111 Malignant melanoma of right upper eyelid, including canthus
- C43.112 Malignant melanoma of right lower eyelid, including canthus
- C43.121 Malignant melanoma of left upper eyelid, including canthus
- C43.122 Malignant melanoma of left lower eyelid, including canthus
- C43.20 Malignant melanoma of unspecified ear and external auricular canal
- C43.21 Malignant melanoma of right ear and external auricular canal
- C43.22 Malignant melanoma of left ear and external auricular canal
- C43.30 Malignant melanoma of unspecified part of face
- C43.31 Malignant melanoma of nose
- C43.39 Malignant melanoma of other parts of face

ICD-10 Codes

- C43.4 Malignant melanoma of scalp and neck
- C43.51 Malignant melanoma of anal skin
- C43.52 Malignant melanoma of skin of breast
- C43.59 Malignant melanoma of other part of trunk
- C43.60 Malignant melanoma of unspecified upper limb, including shoulder
- C43.61 Malignant melanoma of right upper limb, including shoulder
- C43.62 Malignant melanoma of left upper limb, including shoulder
- C43.70 Malignant melanoma of unspecified lower limb, including hip
- C43.71 Malignant melanoma of right lower limb, including hip
- C43.72 Malignant melanoma of left lower limb, including hip
- C43.8 Malignant melanoma of overlapping sites of skin
- C43.9 Malignant melanoma of skin, unspecified