



Requisition User Guide

Please follow the below instructions to complete the test requisition form.

1. Client Information

Account Number:
Account Name:

2. Patient Information

Patient Legal Name (Last, First, MI), Gender, DOB, AND Medical Record number

Requisition Completed by: Signature and Date

Ordering Physician: Name (Last, First), NPI #

Treating Physician: Name (Last, First), NPI #

Test Authorization and Physician Signature: Required information to support medical necessity for the patient's condition.

3. Billing Information for Orders

Complete Specimen Origin: Please choose one option

Bill to: Please specify Client or Insurance billing and include complete patient insurance information to prevent delay in testing

Client Bill: All charges will be billed to Client

Insurance/Medicare/Medicaid: All charges billed to insurance except when payer follows CMS guidelines and patient status indicated as inpatient

Patient/self-pay: All charges billed to patient

Bill charges to other Hospital/Facility: If alternate facility other than listed in above Client information is please indicate name, phone and address here.

ICD diagnosis code: Required information for medical necessity and billing

4. Diagnosis/Patient History

Solid Tumors: Specify type and stage of tumor and please include the most recent copy of pathology report

Hematologic Tumors: Specify type and please include a copy of most recent pathology report and CBC results

ITEMS IN RED ARE REQUIRED TO PERFORM THE TESTING

ANTHOLOGY DIAGNOSTICS
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TEST REQUISITION

Client Information

Account #:
Account Name:
Phone:
Fax:
Street Address:
City:
State:
Zip:

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Billing Information for Orders by Non-Members

Required: Please include face sheet and front/back of patient's insurance card.
 Specimen Origin: Hospital Patient (inpatient) Hospital Patient (outpatient) Non-Hospital Patient (Must Choose 1)
 Bill to: Client Bill Insurance Medicare Medicaid Patient/US Self-Pay Bill charges to other hospital/facility
 ICD code (required):

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Diagnosis/Patient History

Solid Tumors

Type: NSCLC Colorectal Cancer Melanoma Ovarian Breast Brain Prostate Endometrial Stomach Esophageal
 Other, Specify: _____
 Stage: Primary Metastatic
 If Metastasis, list primary: _____
 Relapse Recurrence
 Other Stage: _____
 Please include most recent copy of pathology report

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Hematologic Tumors

Type: AML MDS MPN DLBCL ALL CLL Lymphoma Myeloma
 Other, Specify: _____
 Other Relevant Information: _____
 Ethnicity: _____
 Family History: _____
 Other: _____
 Please include most recent copy of pathology report and CBC

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Specimen Information

Collection Date: _____ Time: _____
 Specimen ID / Block ID: _____
 Fixative/Preservative: 10% Neutral Buffer Formalin Other _____
 Hospital Discharge Date: _____ Body Size: _____
 Peripheral Blood: EDTA-Purple Top Other _____
 Bone Marrow: EDTA-Purple Top Other _____
 Fluid: CSF Pleural Other _____
 FNA cell block: _____
 Slides # _____ Unstained _____ Stained _____
 H&E _____ Paraffin Block(s) #: _____

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Test Selection

Solid Tumors Tests	Types	Genes
<input type="checkbox"/> Anthology Diagnostics -Solid Tumor Profile	DNA	434
<input type="checkbox"/> Anthology Diagnostics -Solid Tumor Fusion/Expression Profile	RNA	1408
<input type="checkbox"/> Anthology Diagnostics -Solid Tumor Profile Plus Fusion/Expression	DNA & RNA	434/1408
<input type="checkbox"/> Anthology Diagnostics -Liquid Biopsy, Solid Tumor	DNA	275

Hematologic Tumors Tests	Types	Genes
<input type="checkbox"/> Anthology Diagnostics -Hematology Profile	DNA	177
<input type="checkbox"/> Anthology Diagnostics -Hematology Fusion/Expression Profile	RNA	1408
<input type="checkbox"/> Anthology Diagnostics -Hematology Profile Plus Fusion/Expression	DNA & RNA	177/1408
<input type="checkbox"/> Anthology Diagnostics -Liquid Biopsy, Hematology Profile	DNA	177

* For Single Gene Testing visit our website

5. Specimen Information

Please include specimen detail of the sample you are submitting, include **collection date**, **specimen ID** and **specimen type**

6. Test Selection

Specify solid tumor or hematologic **test requested** to be performed on patient sample.

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