PRENATAL TEST REQUEST FORM

labcorp

LC1458.03

To find the nearest patient service center, visit Labcorp.com or call 888-Labcorp (888-522-2677).

Patient's Legal Name (Last, First, MI) | Sex | Date of Birth MO DAY YR | Collection Time AM PM | Fasting ☐ Yes ☐ No | Collection Date MO DAY YR | Urine hrs/vol hrs _____ vol _____

NPI | Physician's ID # | Patient's ID # | Hospital Patient Status: ☐ In-Patient ☐ Out-Patient ☐ Non-Patient

Physician's Name (Last, First) | Physician/Authorized Signature X _____

Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service
Highest Specificity REQUIRED

PATIENT

Patient's Address | Phone

City | State | ZIP

Email Address

RESP. PARTY

Name of Policy Holder (if different from patient)

Address of Policy Holder | APT #

City | State | ZIP

PRIMARY BILLING PARTY	SECONDARY BILLING PARTY
Insurance Carrier *	Insurance Carrier *
ID #	ID #
Group #	Group #
Insurance Address	Insurance Address
Name of Insured Person	Name of Insured Person
Relationship to Patient	Relationship to Patient
Employer Name	Employer Name
*If Medicaid State / Physician's Provider #	Workers Comp ☐ Yes ☐ No

I hereby authorize the release of medical information related to the service described herein and authorize payment directly to Labcorp. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.

X _____ Patient's Signature | Date

MEDICARE ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

Refer to policies published by your Medicare Administrative Contractor (MAC), CMS, or www.Labcorp.com/MedicareMedicalNecessity when ordering tests that are subject to ABN guidelines.

CLINICIAN INFORMATION

OTHER TESTS / INDIVIDUAL PROFILE COMPONENTS

TEST # | TEST NAMES

INFORMED CONSENT

I have obtained informed consent for the above ordered genetic test(s). (Required)

Physician's Signature

Please indicate the diagnostic center to which you want screen positive results reported (NY State only)

NONINVASIVE PRENATAL SCREENING (NIPS) MENU — *select only one test*

☐ **451941 MaterniT® GENOME** (9w+) Genome-wide fetal aneuploidies (singleton only)

☐ **452106 MaterniT GENOME** (9w+) No gender

☐ **452104 GENOME-Flex (Add On)** Original MaterniT 21 PLUS specimen re-sequencing, please contact Client Services.

☐ **452114 GENOME-Flex (Add On) Redraw** Original specimen not available, second specimen required for re-sequencing, please contact Client Services.

OR

MaterniT® 21 PLUS Select fetal aneuploidies
Choose one option:

☐ **451927** MaterniT®21 PLUS (9w+)
☐ **451934** MaterniT®21 PLUS + SCA** (9w+) (singleton only)
☐ **451931** MaterniT®21 PLUS + ESS* (9w+)
☐ **451937** MaterniT®21 PLUS + ESS* + SCA** (9w+) (singleton only)
☐ **451951** MaterniT 21 PLUS Core (9w+) No gender
☐ **452112** MaterniT 21 PLUS Core + SCA** (9w+) No gender (singleton only)
☐ **452136** MaterniT 21 PLUS Core + ESS* (9w+) No gender
☐ **452122** MaterniT 21 PLUS Core + ESS* + SCA** (9w+) No gender (singleton only)

* ESS = chr 16, chr 22, and select microdeletions **SCA = sex chromosome aneuploidies

REQUIRED CLINICAL INFORMATION

Gestational age: _____ weeks _____ days *or* EDD: _____

Gestation: ☐ Singleton ☐ Twins ☐ Triplets ☐ Other: _____

Maternal height: _____ ft. _____ in. Maternal weight: _____ lbs.

☐ Yes ☐ No Is patient an insulin dependent diabetic?

☐ Yes ☐ No Egg donor: ☐ Self ☐ Non-self Age of donor at egg retrieval _____

MEDICAL INDICATION(S) FOR GENETIC TESTING

Diagnosis/signs/symptoms in ICD-CM format in effect at date of service (highest specificity required)

Medical indication for testing

☐ Advanced maternal age (ICD-CM: _____)
☐ Positive serum screening (ICD-CM: _____)
☐ Ultrasound findings indicate increased risk (ICD-CM: _____)
☐ Prior pregnancy with trisomy (ICD-CM: _____)
☐ Parental balanced Robertsonian translocation with increased risk of trisomy (ICD-CM: _____)
☐ Family history of NTD (ICD-CM: _____)
☐ Parental cytogenetics following abnormal prenatal results (ICD-CM: _____)
☐ No known high risk for fetal chromosomal aneuploidies (ICD-CM: _____)
☐ Other (ICD-CM: _____)

Preauthorization question

☐ Cell-free DNA testing previously performed during this pregnancy (test name: _____)

CARRIER SCREENING MENU

Specimen type: ☐ Blood ☐ Saliva ☐ Buccal swab

Inheritest® Carrier Screen

☐ **481758** Inheritest® CF/SMA Panel
☐ **481776** Inheritest® Core Panel*
☐ **481797** Inheritest® 14-gene Panel*
☐ **481816** Inheritest® High Frequency Panel*
☐ **481855** Inheritest® 100 PLUS Panel*
☐ **481874** Inheritest® 300 PLUS Panel*
☐ **481893** Inheritest® 500 PLUS Panel*

*Males are not tested for X-linked disorders

☐ **481025** Cystic Fibrosis (CF), 97 Variants
☐ **482632** Cystic Fibrosis (CF) Full-gene Carrier Screen
☐ **481684** Fragile X Syndrome, Carrier
☐ **481701** Fragile X Syndrome, Diagnostic
☐ **481630** Spinal Muscular Atrophy (SMA)
☐ Other testing: _____

☐ **482370** GeneSeq PLUS ☐ VUS opt out

Gene(s): _____

☐ **482552** Targeted Variant Analysis (include report)

Gene: _____

Variant: _____

Partner's name: _____

Partner's DOB: _____

482595 ☐ Partner Reflex to GeneSeq (male partner only) By providing the reproductive partners information, you, the ordering provider, confirm that you have obtained from the patient and reproductive partner all required consents and/or authorizations necessary for the use and disclosure of protected health information, including test results, between the patient and reproductive partner. A separate requisition is required for each partner.

Reflex policy: The following will be performed at an additional charge: Methylation PCR analysis when Fragile X PCR result is >54 CGG repeats; SMN2 analysis when SMN1 result is 0 copies.

REQUIRED CLINICAL INFORMATION

Clinical Information/Single-Gene Testing (If not checked, screening assumed)

☐ No family history ☐ Abnormal fetal u/s* ☐ Family history: relative* ☐ Known carrier* ☐ Infertility
☐ Reproductive partner is known carrier*

*Provide additional information: _____

Race/ethnicities (check all that apply)

☐ African American ☐ Ashkenazi Jewish ☐ Caucasian ☐ East Asian ☐ Finnish ☐ Hispanic
☐ Native American ☐ Sephardic Jewish ☐ South Asian ☐ Other: _____

MEDICAL INDICATION(S) FOR GENETIC TESTING

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ICD-CM		ICD-CM		ICD-CM	

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