labcorp

PRENATAL TEST REQUEST FORM

877.821.7266
womenshealth.labcorp.com
Mon–Fri 5 am–4 pm PST

PLACE BARCODED PATIENT ID LABEL HERE

Sample collection date: _____

PATIENT INFORMATION AND ACKNOWLEDGMENT & PHYSICIAN ACKNOWLEDGMENT

Last name: _____ First name: _____ DOB: _____ Sex: ☐Male ☐Female

Race/ethnicities (check all that apply)

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

Street address: _____ City / State / ZIP: _____

Phone: ( ) _____ Email: _____ MRN (optional): _____

Labcorp may use information obtained on this form and other information provided by the patient and/or ordering provider or his/her designee to initiate preauthorization with the patient's health plan as required. Pretest counseling has occurred with the patient in accordance with patient's health plan requirements if applicable. The patient understands a preauthorization approval from their health plan does not guarantee full payment and the patient accepts financial responsibility for any amounts not covered by their health plan. If applicable, patient authorizes Labcorp to appeal any coverage denial made by carrier on patient's behalf.

Patient's signature: _____ Date: _____

I attest that this patient has been informed about and has given consent for the test(s) I have ordered below under applicable law.

Referring Physician (print): _____ Physician/authorized signature: _____ NPI #: _____ Date: _____

CLINICIAN INFORMATION

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

Specimen type: Blood only

☐ **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 not tested for x-linked disorders

Partner's name: _____
Partner's DOB: _____
☐ **482595** Partner Reflex to GeneSeq (male partner only)
By providing the reproductive partner's 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.

☐ **482370** GeneSeq PLUS ☐ VUS opt out
Gene(s): _____
☐ **482552** Targeted Variant Analysis (include report)
Gene: _____
Variant: _____

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

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*
☐ Reproductive partner is known carrier* ☐ Other*

*Provide additional information: _____

MEDICAL INDICATION(S) FOR GENETIC TESTING

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ICD-CM		ICD-CM		ICD-CM	

LABCORP INTERNAL USE ONLY

BILLING INFORMATION

Patient Hospital Status ☐ Inpatient ☐ Outpatient ☐ Non-hospital ☐ Medicaid ☐ Medicare ☐ Insurance ☐ Client bill ☐ CA XAFP ☐ Self-pay ☐ Billing information attached *(Please include a copy of insurance card or face sheet.)*
Do not attached credit card information to this form for security purposes.

Insurance company name: _____ Policy #: _____ Group #: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Patient's signature: _____ Date: _____