labcorp

Comprehensive Genetics

1900.35

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 _____ | Genetic Counselor (Last,First)

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

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

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

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.

OTHER TESTS / INDIVIDUAL PROFILE COMPONENTS

TEST #	TEST NAMES

Specimen Type (Check one):

Patient ☐Peripheral Blood ☐Other
Parental ☐Peripheral Blood ☐Other
Fetal ☐Fetal/Cord Blood ☐Amniotic Fluid ☐Chorionic Villi ☐POC

☐Hold Cells

Fetal sex: ☐Male ☐Female ☐Unknown
By: ☐U/S ☐NIPS ☐PGT

Gestational Age (required) _____

Egg donor: ☐Self ☐Non-self

Maternal blood for MCC required with fetal molecular testing

Ethnicities (Check all that apply):

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

Indication(s) for Test (check all that apply)

Diagnostic: ☐Known affected
☐Family history (attach pedigree)
☐Abnormal newborn screen
☐Suspected: symptoms _____

Carrier: ☐No family history (screening)
☐Family history (attach pedigree)
☐Familial mutation: specify _____
☐Abnormal fetal ultrasound: specify _____

Fetal: ☐Family history (attach pedigree)
☐Abnormal fetal ultrasound: specify _____
☐AMA
☐Abnormal Maternal serum screening: specify _____
☐Abnormal Noninvasive Prenatal Screening (NIPS): provide report & specify _____

Are parents related (consanguinity): ☐Yes ☐No
(If yes how: _____)

Other Clinical Information Comments:

INFORMED CONSENT

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

_____
Physician Signature

PRENATAL BIOCHEMICAL GENETICS AND CYTOGENETICS

002428	☐	AFP, Amniotic Fluid (specify GA; reflexes to AChE if positive)
510305	☐	AFP, AChE with reflex to HbF
511580	☐	Chromosome, AFP/AChE/HbF, Amniotic Fl (specify GA)
510185	☐	Chromosome, AFP, Amniotic Fl (specify GA)
052052	☐	Chromosome, Biopsies (POC, Skin)
052104	☐	Chromosome, Amniotic Fluid Reflex SNP Microarray (Reveal®) (include prenatal SNP questionnaire)
511590	☐	Chromosome Five-cell Count Plus Microarray (Reveal®), Amniotic Fluid (include prenatal SNP questionnaire)
510988	☐	Chromosome, Chorionic Villus (specify GA)
511033	☐	Chromosome, CVS Reflex SNP Microarray (Reveal®) (include prenatal SNP questionnaire)
511555	☐	Chromosome Five-cell Count Plus Microarray (Reveal®), CVS (include prenatal SNP questionnaire)
511025	☐	Chromosome, Cordocentesis/HbF (specify GA)
510100	☐	SNP Microarray (Culture only)–Prenatal (Reveal®) (include prenatal SNP questionnaire)
510110	☐	SNP Microarray-POC/Tissue (Reveal®) (include prenatal SNP questionnaire)
510200	☐	SNP Microarray (Direct) – Prenatal (Reveal®) (include prenatal SNP questionnaire)
052065	☐	Chromosome, POC, if no growth, Reflex SNP Microarray (Reveal®) (include prenatal SNP questionnaire)
511997	☐	Reveal® POC Paraffin (include prenatal SNP questionnaire)
511966	☐	FISH, InSight rflx to Chromosome or Microarray, Amniotic Fluid
511625	☐	FISH, InSight rflx to Chromosome or Microarray, CVS
511894	☐	FISH, InSight Aneuploid Evaluation, Amniotic Fluid (specify GA)
510960	☐	FISH, InSight Aneuploid Evalution, CVS (specify GA)
510770	☐	FISH, Microdeletion Syndromes (specify GA & probe)

POSTNATAL CYTOGENETICS

052215	☐	Chromosome, High Resolution
511035	☐	Chromosome, Blood, Routine
052045	☐	Chromosome Reflex SNP Microarray–Pediatric (Reveal®) (include SNP questionnaire)
511535	☐	Chromosome Five-cell Count Plus Microarray (Reveal®), Blood (include SNP questionnaire)
511045	☐	Chromosome, Instability Syndrome
512138	☐	Chromosome Analysis, Blood Reflex Y Deletion Analysis (male infertility)
510002	☐	SNP Microarray-Pediatric (Reveal®) (include SNP questionnaire)
510770	☐	FISH, Microdeletion Syndromes (Specify probe) _____

INBORN ERRORS OF METABOLISM

700068	☐	Amino Acid Profile, Quantitative, Plasma
700140	☐	Amino Acid Profile, Quantitative, Urine
700180	☐	Amino Acid Profile, Quantitative, CSF
716720	☐	Organic Acid Analysis, Urine
070228	☐	Acylcarnitine Profile, Plasma
706500	☐	Carnitine, Total and Free
007010	☐	Orotic Acid, Urine
402300	☐	Lysosomal Acid Lipase (LAL) Deficiency
402362	☐	Biotinidase Deficiency, Enzyme
402388	☐	Alpha-Galactosidase A Deficiency, Enzyme
402396	☐	Arylsulfatase A Deficiency, Enzyme
402370	☐	β-Galactosidase Deficiency, Enzyme
510412	☐	Tay-Sachs Disease, Biochemical, Serum
511246	☐	Tay-Sachs Disease, Biochemical, Leukocytes

*Reflex testing will cause additional CPT codes to be billed.
Complete test information can be found at Labcorp.com. For questions, call Customer Service at 800-345-4363 (GENE) or email AskCMBP@Labcorp.com.

MOLECULAR GENETICS

511172	☐	α-Thalassemia, DNA Analysis+
511881	☐	α_1-Antitrypsin Deficiency, DNA Analysis+
511210	☐	Angelman and Prader-Willi Syndromes, DNA Analysis#
252823	☐	β-Thalassemia: *HBB* (Full Gene Sequencing)
252867	☐	β-Thalassemia: *HBB* (Full Gene Sequencing) Fetal Analysis^
481025	☐	Cystic Fibrosis (CF), 97 Variants
481573	☐	Cystic Fibrosis (CF) 97 Variants, Fetal Analysis^
482632	☐	Cystic Fibrosis (CF) Full-gene Carrier Screen
511162	☐	Factor II (Prothrombin), DNA Analysis
511154	☐	Factor V Leiden Mutation Analysis
481684	☐	Fragile X Syndrome, Carrier
481701	☐	Fragile X Syndrome, Diagnostic
481718	☐	Fragile X Syndrome, Fetal Analysis^
482370	☐	GeneSeq PLUS ☐VUS opt out for gene(s):
482389	☐	GeneSeq PLUS, Fetal Analysis^ ☐VUS opt out for gene(s):
482449	☐	GeneSeq PLUS, CFTR
482884	☐	GeneSeq PLUS, HEXA (Tay Sachs)
511405	☐	GJB2 DNA Sequencing+
252225	☐	GLA Sequencing+
511345	☐	Hereditary Hemochromatosis, DNA Analysis
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
511402	☐	Maternal Cell Contamination to confirm fetal testing _____
511277	☐	MECP2 DNA Sequencing+
511238	☐	MTHFR Thermolabile Variant, DNA Analysis
482299	☐	Noonan Syndrome, Fetal Analysis^
482091	☐	Sickle Cell, Fetal Analysis^
481630	☐	Spinal Muscular Atrophy (SMA)
481651	☐	Spinal Muscular Atrophy (SMA), Fetal Analysis^
482552	☐	Targeted Variant Analysis (familial report required) Gene: _____ Variant: _____
482534	☐	Targeted Variant Analysis, Fetal Analysis^ (familial report required) Gene: _____ Variant: _____
470074	☐	UPD DNA Analysis Proband+ (specify chromosome) _____
470115	☐	UPD DNA Analysis Parent (specify chromosome) _____
512116	☐	Y Chromosome Microdeletion Analysis

+ indicates testing can also be performed on CVS or amnio
^ indicates CVS or amnio must be submitted for evaluation
# indicates testing can also be performed on amnio

NOTE: WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDICAID REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT. COMPONENTS OF THE TEST COMBINATIONS / PROFILES PRINTED BELOW ARE SHOWN ON THE REVERSE SIDE AND MAY ALSO BE ORDERED INDIVIDUALLY BELOW. COMPONENTS MAY BE BILLED SEPARATELY PER CARRIER POLICY.

[REV 08/11/2023]