GENETIC CARRIER & PRENATAL SCREENING

progenity®

☐ FEMALE PATIENT ☐ MALE PATIENT

LAST NAME

FIRST NAME

PATIENT ID

DATE OF BIRTH (MM/DD/YYYY) | TELEPHONE NUMBER

☐ Asian ☐ African American/Black ☐ Hispanic
☐ Caucasian/White ☐ Jewish, Ashkenazi ☐ Other/Mixed/Unknown _____

EMAIL

STREET NUMBER | STREET NAME | APT NUMBER

CITY | STATE | ZIP

ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I am responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031 (b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim. I authorize information to be shared with my partner if also undergoing testing.

☐ I authorize the laboratory to retain and use my de-identified specimen and test data (where all information that could link me to the specimen or data has been removed) for research and/or help develop new products or services, in compliance with applicable laws.

☐ I do not authorize the laboratory to retain and use my de-identified specimen and test data as described above.

All leftover specimens from New York State will be destroyed within 60 days.

REQUIRED PATIENT SIGNATURE X DATE (MM/DD/YY)

CLINICIAN INFO

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The patient has completed pre-testing genetic counseling. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.

REQUIRED ORDERING CLINICIAN SIGNATURE X DATE (MM/DD/YY)

ADDITIONAL REPORTS TO: CLINICIAN NAME

NPI# | FAX NUMBER

BILLING INFO

☐ **BILL INSURANCE** Attach legible front and back copy of insurance cards.

INSURANCE COMPANY | IPA NAME

MEMBER ID | PRIOR AUTHORIZATION, IF NEEDED

☐ **BILL PATIENT** Patient will be contacted to provide payment method.
☐ **CLIENT BILL**

PREGNANCY INFO – REQUIRED FOR FEMALE PATIENTS

Is patient pregnant?
☐ NO Z31.430
☐ YES, singleton
☐ YES, twin
☐ YES, other:
#_____

First pregnancy?
☐ YES, primigravida
☐ NO, multigravida

Which trimester?
☐ First Z34.01/81
☐ Second Z34.02/82
☐ Third Z34.03/83

EST. DATE OF DELIVERY (MM/DD/YY)

DATING METHOD ☐ LMP ☐ Ultrasound

PATIENT HEIGHT FT IN

PATIENT WEIGHT LBS

IVF pregnancy? ☐ NO ☐ YES 009.811

Egg donor/gestational carrier used? ☐ NO ☐ YES

AGE OF PATIENT/DONOR AT EGG RETRIEVAL

SPECIMEN INFO – REQUIRED

Collected on: | Time: : ☐ AM ☐ PM

Collected by: _____

Collection Requirement Key: See Specimen Guide for additional specimen types

- 4 mL Lavender-top EDTA tube
- 8.5 mL Yellow-top ACD tube
- 10 mL Streck DNA tube
- 4 mL serum separator tube (SST)

CARRIER TESTING

PREPARENT® CARRIER TEST

- ☐ 3901 **Trio Carrier Test**[1] 3 genes *CFTR, FMR1, SMN1/2*
- ☐ 3505 **Core Carrier Test**[1] 5 genes *CFTR, FMR1, SMN1/2, HBA1/2, HBB*
- ☐ 3507 **Select Carrier Test**[1] 13 genes *CFTR, FMR1, SMN1/2, HBA1/2, HBB, PMM2, GALT, GBA, G6PC, ACADM, PAH, DHCR7, HEXA*
- ☐ 3500 **Standard Carrier Test**[1,2] 24 genes
- ☐ 2300 **Ashkenazi Jewish Carrier Test**[1] 35 genes
- ☐ 3501 **Global Carrier Test**[1,2] 200+ genes
- ☐ 3502 **Global+ Carrier Test**[1,2] 210+ genes

Visit progenity.com/performance for gene list

- ☐ **Other** *All tests can be ordered individually.* _____
- ☐ 2004 **Cystic Fibrosis** *CFTR 600 mutations*
- ☐ 2400 **Spinal Muscular Atrophy** *SMN1/2*
- ☐ 2500 **Fragile X Syndrome**[1] *FMR1*

NON-DNA TEST OPTIONS

- ☐ 3300 **Hemoglobinopathy Evaluation** *hemoglobin electrophoresis and RBC indices Description on reverse.*
- ☐ 2201 **Tay-Sachs Disease Enzyme Analysis** *hexosaminidase A*

☐ 2502 ***OPT OUT of Xpansion Interpreter®*** *for Fragile X results with 55 – 90 CGG repeats*

[1] *Fragile X is not tested in males. The following will be performed by reflex at additional charge: Xpansion Interpreter® AGG interruption analysis for Fragile X results with 55-90 CGG repeats unless opted-out above.*
[2] *In certain cases based on health plan policy, orders for Standard, Global, or Global+ carrier tests may be adjusted to a smaller test.*

CLINICAL INFO

REQUIRED - Family history of genetic disorder?
☐ NO, and patient is female Z31.430
☐ NO, and patient is male Z31.440
☐ YES, Hereditary genetic disorder Z84.81 *(specify condition)*
☐ YES, Musculoskeletal disorder Z82.69 *(specify condition)*

SPECIFY CONDITION

RELATIONSHIP TO PATIENT OR PARTNER

☐ Patient had previous carrier testing (attach report)
☐ Patient had a blood transfusion (past 3 months) or a bone marrow/organ transplant

OTHER DIAGNOSIS (SPECIFY ICD-10)

PARTNER INFO

PARTNER'S DATE OF BIRTH (MM/DD/YYYY)

PARTNER'S FIRST NAME

PARTNER'S LAST NAME

PRENATAL SCREENING

INNATAL® PRENATAL SCREEN *Gestational age 10 weeks or later*

Test ordered will be processed and billed based upon health plan policy.

- ☐ 2800 **Singleton Pregnancy** noninvasive screening for chromosomes 21, 18, 13, X, and Y
  - ☐ ***OPT OUT*** *of screening for sex chromosome aneuploidies (no fetal sex information)*
- ☐ 2800 **Twin Pregnancy** noninvasive screening for chromosomes 21, 18, 13, and Y
  - ☐ ***OPT OUT*** *of screening for Y chromosome (no fetal sex information)*

CLINICAL INFO

REQUIRED - Is patient at increased risk for aneuploidy (i.e., Down syndrome)?
☐ NO, patient is average risk. Z13.79
☐ YES, advanced maternal age (35+ at EDD) O09.511, 512, 513, 519, 521, 522, 523, 529
☐ YES, abnormal serum screening O28.1 *(specify aneuploidy risk)*
☐ YES, ultrasound indicating structural anomaly O28.3 *(specify aneuploidy risk)*
☐ YES, prior pregnancy w/ aneuploidy Z82.79 *(specify condition)*
☐ YES, family history of chromosomal abnormality Z82.79 *(specify condition)*
☐ YES, patient history of chromosomal abnormality *(specify condition)*

SPECIFY CONDITION OR ANEUPLOIDY RISK RESULT

☐ Patient had a blood transfusion (past 3 months) or a bone marrow/organ transplant

OTHER DIAGNOSIS (SPECIFY ICD-10)

MATERNAL SERUM SCREENING

Patient weight is required for all maternal serum screening tests.

- ☐ 2901 **First Trimester Screen** (PAPP-A, hCG) *Gestational age 10 – 13 weeks 6 days*
  - ! ***Requires nuchal translucency ultrasound.*** *For twins, attach separate form: progenity.com/ultrasound*
- ☐ 2902 **Second Trimester Quad Screen** (AFP, uE3, hCG, DIA) *Gestational age 15 – 22 weeks 6 days*
- ☐ 2900 **Open Neural Tube Screen** (AFP) *Gestational age 15 – 22 weeks 6 days*

ULTRASOUND INFO

ULTRASOUND DATE

CROWN RUMP LENGTH mm (34.0 – 85.0)

NUCHAL TRANSLUCENCY mm

Nasal Bone: ☐ Not evaluated ☐ Present ☐ Absent

SONOGRAPHER NAME

SONOGRAPHER ID

Credentialed by: ☐ NTQR ☐ FMF ☐ Other

CLINICAL INFO

☐ Patient is an insulin-dependent diabetic
☐ Patient smokes cigarettes

OTHER DIAGNOSIS (SPECIFY ICD-10)

PATIENT NAME_____ DATE OF BIRTH_____ | PATIENT NAME_____ DATE OF BIRTH_____ | PATIENT NAME_____ DATE OF BIRTH_____ | PATIENT NAME_____ DATE OF BIRTH_____

HEMOGLOBINOPATHY EVALUATION

Methodology for the Hemoglobinopathy Evaluation includes hemoglobin electrophoresis and red blood cell indices.

Analytes include:
- Red blood cell count
- Hemoglobin
- Hematocrit
- Mean corpuscular volume (MCV)
- Mean corpuscular hemoglobin (MCH)
- Red cell distribution width (RDW)
- Hemoglobin electrophoresis

CLINICAL INDICATIONS

GENETIC CARRIER SCREENING

Screening for other metabolic disorders	Z13.228
Nonprocreative screening for genetic disease carrier status	Z13.71
Female for testing for genetic disease carrier status for procreative management	Z31.430
Male for testing for genetic disease carrier status for procreative management	Z31.440
Supervision of normal first pregnancy, first trimester	Z34.01
Supervision of normal first pregnancy, second trimester	Z34.02
Supervision of normal first pregnancy, third trimester	Z34.03
Supervision of other normal pregnancy, first trimester	Z34.81
Supervision of other normal pregnancy, second trimester	Z34.82
Supervision of other normal pregnancy, third trimester	Z34.83
Supervision of normal pregnancy, unspecified, first trimester	Z34.91
Supervision of normal pregnancy, unspecified, second trimester	Z34.92
Supervision of normal pregnancy, unspecified, third trimester	Z34.93
Family history of intellectual disabilities	Z81.0
Family history of other diseases of the musculoskeletal system and connective tissue	Z82.69
Family history of carrier of genetic disease	Z84.81

PRENATAL ANEUPLOIDY SCREENING

Supervision of pregnancy with history of infertility, first trimester	O09.01
Supervision of pregnancy with history of infertility, second trimester	O09.02
Supervision of pregnancy with other poor reproductive or obstetric history, first trimester	O09.291
Supervision of pregnancy with other poor reproductive or obstetric history, second trimester	O09.292
Supervision of elderly primigravida, first trimester	O09.511
Supervision of elderly primigravida, second trimester	O09.512
Supervision of elderly primigravida, third trimester	O09.513
Supervision of elderly multigravida, first trimester	O09.521
Supervision of elderly multigravida, second trimester	O09.522
Supervision of elderly multigravida, third trimester	O09.523
Supervision of pregnancy resulting from assisted reproductive technology, first trimester	O09.811
Supervision of pregnancy resulting from assisted reproductive technology, second trimester	O09.812
Supervision of pregnancy resulting from assisted reproductive technology, third trimester	O09.813
Supervision of other high risk pregnancies, first trimester	O09.891
Supervision of other high risk pregnancies, second trimester	O09.892
Supervision of other high risk pregnancies, third trimester	O09.893
Abnormal hematological finding on antenatal screening of mother	O28.0
Abnormal biochemical finding on antenatal screening of mother	O28.1
Abnormal cytological finding on antenatal screening of mother	O28.2
Abnormal ultrasonic finding on antenatal screening of mother	O28.3
Abnormal radiological finding on antenatal screening of mother	O28.4
Abnormal chromosomal and genetic finding on antenatal screening of mother	O28.5
Other abnormal findings on antenatal screening of mother	O28.8
Unspecified abnormal findings on antenatal screening of mother	O28.9
Maternal care for (suspected) chromosomal abnormality in fetus, fetus 1	O35.1XX1
Maternal care for (suspected) hereditary disease in fetus, fetus 1	O35.2XX1
Other screening for genetic and chromosomal anomalies	Z13.79
Family history of other disabilities and chronic diseases leading to disablement, not elsewhere classified	Z82.8

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