

FEMALE PATIENT MALE PATIENT

LAST NAME _____

FIRST NAME _____

PATIENT ID _____

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

Asian African American/Black Hispanic
 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** _____ DATE (MM/DD/YY) _____

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 _____

CARRIER TESTING

PREPARENT® CARRIER TEST

- 3901 **Trio Carrier Test**¹ 3 genes *CFTR, FMRI, SMN1/2*
- 3505 **Core Carrier Test**¹ 5 genes *CFTR, FMRI, SMN1/2, HBA1/2, HBB*
- 3507 **Select Carrier Test**¹ 13 genes *CFTR, FMRI, SMN1/2, HBA1/2, HBB, PMM2, GALT, GBA, G6PC, ACADM, PAH, DHCRT, HEXA*
- 2300 **Ashkenazi Jewish Carrier Test**¹ 35 genes
- 3501 **Global Carrier Test**^{1,2} 200+ genes *progenity.com/performance for gene list*
- 3502 **Global+ Carrier Test**^{1,2} 210+ genes
- Other All tests can be ordered individually.

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 Global or Global+ carrier tests may be adjusted to a smaller test.

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)

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

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 test(s) requested herein.

REQUIRED **ORDERING CLINICIAN SIGNATURE** _____ **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

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)

CLINICAL INFO

REQUIRED - Family history of genetic disorder? SPECIFY CONDITION

- 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)

RELATIONSHIP TO PATIENT OR PARTNER _____

OTHER DIAGNOSIS (SPECIFY ICD-10) _____

Patient had previous carrier testing (attach report)

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

PARTNER INFO

PARTNER'S FIRST NAME _____

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

PARTNER'S LAST NAME _____

CLINICAL INFO

REQUIRED - Is patient at increased risk for aneuploidy (i.e., Down syndrome)? SPECIFY CONDITION OR ANEUPLOIDY RISK RESULT

- NO, patient is average risk. Z13.79
- YES, advanced maternal age (35+ at EDD) 009.511, 512, 513, 519, 521, 522, 523, 529
- YES, abnormal serum screening 028.1 (specify aneuploidy risk)
- YES, ultrasound indicating structural anomaly 028.3 (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)

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

OTHER DIAGNOSIS (SPECIFY ICD-10) _____

ULTRASOUND INFO

ULTRASOUND DATE _____

Nasal Bone: Not evaluated Present Absent

SONOGRAPHER NAME _____

CROWN RUMP LENGTH _____ mm (34.0 – 85.0)

SONOGRAPHER ID _____

NUCHAL TRANSLUCENCY _____ mm

Credentialed by: NTQR FMF Other _____

CLINICAL INFO

Patient is an insulin-dependent diabetic

Patient smokes cigarettes

OTHER DIAGNOSIS (SPECIFY ICD-10) _____

HEMOGLOBINOPATHY EVALUATION

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

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

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	009.01
Supervision of pregnancy with history of infertility, second trimester	009.02
Supervision of pregnancy with other poor reproductive or obstetric history, first trimester	009.291
Supervision of pregnancy with other poor reproductive or obstetric history, second trimester	009.292
Supervision of elderly primigravida, first trimester	009.511
Supervision of elderly primigravida, second trimester	009.512
Supervision of elderly primigravida, third trimester	009.513
Supervision of elderly multigravida, first trimester	009.521
Supervision of elderly multigravida, second trimester	009.522
Supervision of elderly multigravida, third trimester	009.523
Supervision of pregnancy resulting from assisted reproductive technology, first trimester	009.811
Supervision of pregnancy resulting from assisted reproductive technology, second trimester	009.812
Supervision of pregnancy resulting from assisted reproductive technology, third trimester	009.813
Supervision of other high risk pregnancies, first trimester	009.891
Supervision of other high risk pregnancies, second trimester	009.892
Supervision of other high risk pregnancies, third trimester	009.893
Abnormal hematological finding on antenatal screening of mother	028.0
Abnormal biochemical finding on antenatal screening of mother	028.1
Abnormal cytological finding on antenatal screening of mother	028.2
Abnormal ultrasonic finding on antenatal screening of mother	028.3
Abnormal radiological finding on antenatal screening of mother	028.4
Abnormal chromosomal and genetic finding on antenatal screening of mother	028.5
Other abnormal findings on antenatal screening of mother	028.8
Unspecified abnormal findings on antenatal screening of mother	028.9
Maternal care for (suspected) chromosomal abnormality in fetus, fetus 1	035.1XX1
Maternal care for (suspected) hereditary disease in fetus, fetus 1	035.2XX1
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