REQUESTED BY

labcorp

PRECONCEPTION & PREGNANCY

0900.40

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

APPLY LABELS TO PATIENT SPECIMENS ONLY.

1A 1B 1C

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

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 Labcorp.com/MedicareMedicalNecessity when ordering tests that are subject to ABN guidelines.

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)

PLEASE PRINT

PLEASE PRINT

Additional tests available. Call Genetics Services for info. 1-800-345-GENE

MATERNAL PLASMA SCREENING: NON INVASIVE PRENATAL TESTING (NIPT)

451927	☐	MaterniT®21 PLUS (9w+)
451931	☐	MaterniT®21 PLUS w/ ESS* (9w+)
451934	☐	MaterniT®21 PLUS w/ SCA** (9w+)
451937	☐	MaterniT®21 PLUS w/ ESS & SCA** (9w+)
451941	☐	MaterniT® Genome (9w+)
451951	☐	MaterniT®21 PLUS No Gender (9w+)
452104	☐	GENOME-Flex** (Add On)
452114	☐	GENOME-Flex** (Add On) Redraw

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

GA ____ wks ____ days on date ____/____/____
By ☐ LMP ☐ EDC/EDD ☐ U/S

Indication for Non Invasive Prenatal Testing (NIPT)

☐ AMA ☐ Positive maternal serum screening test
☐ Previous pregnancy with aneuploidy
☐ Family history of chromosomal abnormality
☐ Ultrasound findings (Check all that apply):
☐ cystic hygroma ☐ IUGR ☐ heart defect ☐ CNS abnormality
☐ Other: _____

MATERNAL SERUM SCREENING W/O NT

017200	☐	Serum Integrated 1 (10w0d-14w0d)
017270	☐	Serum Integrated 2 (15w0d-21w6d)
017319	☐	AFP Tetra (15w0d-21w6d)
010801	☐	msAFP (15w0d-23w6d) (optimal 16w-18w6d)

MATERNAL SERUM SCREENING W NT

017500	☐	1st Trimester Screen (10w0d-13w6d)
017700	☐	Sequential Part 1 (10w0d-14w0d)
017750*	☐	Sequential Part 2 (15w0d-21w6d)
017100	☐	Integrated Part 1 (10w0d-14w0d)
017170*	☐	Integrated Part 2 (15w0d-21w6d)

CARRIER SCREENING

480533	☐	Cystic Fibrosis (32)
450020	☐	CF*plus*® (97 mutation test)
511919	☐	Frag X, PCR w/ rflx to Southern blot analysis**
450010	☐	Spinal Muscular Atrophy
121690	☐	Hgb Fractionation Cascade
511172	☐	α-Thalassemia, DNA Analysis
252823	☐	β-Thalassemia: *HBB* (Full Gene Sequencing)

Inheritest® Carrier Screen

451910	☐	Gene-specific Sequencing**

Required: Gene (s) _____

451950	☐	Inheritest® Comprehensive Panel (144 genes)
451920	☐	Inheritest® Ashkenazi Jewish Panel (48 genes)
451960	☐	Inheritest® Society-guided Panel (14 genes)
451964	☐	Inheritest® Core (CF97, SMA, FragX)
452172	☐	Inheritest® CF/SMA Panel

PREGNANCY COMPLICATIONS

005199	☐	Prothrombin Time (PT)
005207	☐	PTT, Activated (APTT)
365200	☐	IUFD Profile
365300	☐	IUFD Extended Profile
161802	☐	Anticardiolipin Ab, IgG, IgM
015594	☐	Antithrombin Deficiency Profile
001610	☐	Fibrinogen Activity
511162	☐	Factor II (Prothrombin)
511154	☐	Factor V Leiden
706994	☐	Homocysteine
365500	☐	Inherited Thrombophilias of Preg
117892	☐	Lupus Anticoagulant w Reflex
511238	☐	MTHFR
283655	☐	Protein C Deficiency Profile
117754	☐	Protein S Deficiency Profile
504295	☐	ReproSURE™ (Ovarian Reserve Profile) See Reverse GEL

** Reflex testing will cause additional CPT codes to be billed.

NT MEASUREMENTS

CRL date ____/____/____ *Twin B, if applicable*
CRL ____.____ mm (45.0-84.0) NT ____.____ mm Chorionicity: ☐ Mono ☐ DI
CRL ____.____ mm (45.0-84.0) NT ____.____ mm ☐ Unknown

Sonographer Name+: Last _____ First _____
Sonographer ID #: _____ Credentialed by ☐ NTQR ☐ FMF ☐ Other
Reading MD ID #: _____ Site ID#: _____
Nasal Bone: ☐ Not Evaluated ☐ Present ☐ Absent NB Twin B ☐ Present ☐ Absent

Please also check YES under "Other Indications" in Clinical History section if NB data provided.
* Gestational age will be based on CRL data provided for Part 1. Integrated & Sequential Testing options require 2 specimens within a specified period. Part 2 follow-up information will be listed on the Part 1 report.
+ The NT and nasal bone must be performed by a sonographer credentialed by the FMF, NTQR or equivalent entity.

REQUIRED INFORMATION

Patient Weight _____ lbs
# of Fetuses ☐ 1 ☐ 2 ☐ Other _____
Patient Race ☐ Cauc ☐ Hispanic ☐ Black ☐ Asian ☐ Amer Indian ☐ Other
☐ Yes ☐ No Is patient an insulin dependent diabetic?
☐ Yes ☐ No Egg donor: ☐ Self ☐ Non-self
Age of donor at egg retrieval: _____ years

CLINICAL HISTORY

☐ Yes ☐ No Prior Down Syndrome/ONTD Screen in Current Pregnancy? If yes, prior test was: ☐ in 1st Tri ☐ in 2nd Tri ☐ elevated msAFP
☐ Yes ☐ No Family history of NTD?
☐ Yes ☐ No Previous pregnancy with Down Syndrome?
☐ Yes ☐ No Parental cytogenetics following abnormal prenatal results.
☐ Yes ☐ No Parental balanced Robertsonian Translocation with increased risk of Trisomy.
☐ Yes ☐ No Other Indications : _____

CYTOGENETICS

Amniotic Fluid (specify GA above)

511580	☐	Chromosome & AFP/AChE/HbF
052040	☐	Chromosome Analysis
002428	☐	AFP, Amniotic fluid
510305	☐	AFP, AChE with reflex to HbF
511894	☐	InSight®:Prenatal Amnio Aneuploid FISH
052104	☐	Chromosome rfx Reveal® SNP Microarray
511966	☐	FISH, rfx chrom. or Reveal® SNP Microarray
511590	☐	Chrom. 5 Count + Reveal® SNP Microarray
510100	☐	SNP Microarray-Prenatal (Reveal®)
510200	☐	SNP Microarray (Direct)-Prenatal (Reveal®)

Chorionic Villi (specify GA above)

510988	☐	Chromosome Analysis
510960	☐	InSight® Prenatal CVS Aneuploid FISH
511033	☐	Chromosome rfx Reveal® SNP Microarray
511625	☐	FISH, rfx Chrom. or Reveal® SNP Microarray
511555	☐	Chrom. 5 cell + Reveal® SNP Microarray
510100	☐	SNP Microarray - Prenatal (Reveal®)
510200	☐	SNP Microarray (Direct) - Prenatal (Reveal®)

POC / Tissue / Other (specify GA above)

052052	☐	Chromosome Analysis
510110	☐	Reveal® SNP Microarray
052065	☐	Chromosome rfx Reveal® SNP Microarray
511035	☐	Chromosome, Blood
510770	☐	FISH Microdeletion (Specify)
511402	☐	Maternal cell contamination

Hold cells ☐

Clin Info, Fam Hx, Other _____
Abnl NIPT: Specify _____ Fetal Gender: ☐ Male ☐ Female ☐ Unknown

1-FORWARD TO LABCORP WITH SPECIMEN-RETAIN LAST COPY

ORIGINAL-LABORATORY / COPY-CLIENT

ITEM # 007261 9 FORM # 0900 2pt

R E Q U E S T E D B Y

1A 1B 2C

labcorp

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PRECONCEPTION & PREGNANCY

0900.40

APPLY LABELS TO PATIENT SPECIMENS ONLY.

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

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

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X
Patient's Signature — Date

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GA ____ wks ____ days on date ____/____/____
By ☐ LMP ☐ EDC/EDD ☐ U/S

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☐ Ultrasound findings (Check all that apply):
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452172	☐	Inheritest® CF/SMA Panel

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005207	☐	PTT, Activated (APTT)
365200	☐	IUFD Profile
365300	☐	IUFD Extended Profile
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015594	☐	Antithrombin Deficiency Profile
001610	☐	Fibrinogen Activity
511162	☐	Factor II (Prothrombin)
511154	☐	Factor V Leiden
706994	☐	Homocysteine
365500	☐	Inherited Thrombophilias of Preg
117892	☐	Lupus Anticoagulant w Reflex
511238	☐	MTHFR
283655	☐	Protein C Deficiency Profile
117754	☐	Protein S Deficiency Profile
504295	☐	ReproSURE™ (Ovarian Reserve Profile) See Reverse (GEL)

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NT MEASUREMENTS

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Twin B, if applicable CRL ____.____ mm (45.0-84.0) NT ____.____ mm ☐ Unknown
Sonographer Name+: Last ________ First ________
Sonographer ID #: ________ Credentialed by ☐ NTQR ☐ FMF ☐ Other
Reading MD ID #: ________ Site ID#: ________
Nasal Bone: ☐ Not Evaluated ☐ Present ☐ Absent NB Twin B ☐ Present ☐ Absent
Please also check YES under "Other Indications" in Clinical History section if NB data provided.
* Gestational age will be based on CRL data provided for Part 1. Integrated & Sequential Testing options require 2 specimens within a specified period. Part 2 follow-up information will be listed on the Part 1 report.
\+ The NT and nasal bone must be performed by a sonographer credentialed by the FMF, NTQR or equivalent entity.

REQUIRED INFORMATION

Patient Weight ________ lbs
\# of Fetuses ☐ 1 ☐ 2 ☐ Other ____
Patient Race ☐ Cauc ☐ Hispanic ☐ Black ☐ Asian ☐ Amer Indian ☐ Other
☐ Yes ☐ No Is patient an insulin dependent diabetic?
☐ Yes ☐ No Egg donor: ☐ Self ☐ Non-self
Age of donor at egg retrieval: ____ years

CLINICAL HISTORY

☐ Yes ☐ No Prior Down Syndrome/ONTD Screen in Current Pregnancy? If yes, prior test was: ☐ in 1st Tri ☐ in 2nd Tri ☐ elevated msAFP
☐ Yes ☐ No Family history of NTD?
☐ Yes ☐ No Previous pregnancy with Down Syndrome?
☐ Yes ☐ No Parental cytogenetics following abnormal prenatal results.
☐ Yes ☐ No Parental balanced Robertsonian Translocation with increased risk of Trisomy.
☐ Yes ☐ No Other Indications : ________

CYTOGENETICS

Amniotic Fluid (specify GA above)

511580	☐	Chromosome & AFP/AChE/HbF
052040	☐	Chromosome Analysis
002428	☐	AFP, Amniotic fluid
510305	☐	AFP, AChE with reflex to HbF
511894	☐	InSight®:Prenatal Amnio Aneuploid FISH
052104	☐	Chromosome rfx Reveal® SNP Microarray
511966	☐	FISH, rfx chrom. or Reveal® SNP Microarray
511590	☐	Chrom. 5 Count + Reveal® SNP Microarray
510100	☐	SNP Microarray-Prenatal (Reveal®)
510200	☐	SNP Microarray (Direct)-Prenatal (Reveal®)

Chorionic Villi (specify GA above)

510988	☐	Chromosome Analysis
510960	☐	InSight® Prenatal CVS Aneuploid FISH
511033	☐	Chromosome rfx Reveal® SNP Microarray
511625	☐	FISH, rfx Chrom. or Reveal® SNP Microarray
511555	☐	Chrom. 5 cell + Reveal® SNP Microarray
510100	☐	SNP Microarray - Prenatal (Reveal®)
510200	☐	SNP Microarray (Direct) - Prenatal (Reveal®)

POC / Tissue / Other (specify GA above)

052052	☐	Chromosome Analysis
510110	☐	Reveal® SNP Microarray
052065	☐	Chromosome rfx Reveal® SNP Microarray
511035	☐	Chromosome, Blood
510770	☐	FISH Microdeletion (Specify)
511402	☐	Maternal cell contamination

Hold cells ☐

Clin Info, Fam Hx, Other ________
Abnl NIPT: Specify ________ Fetal Gender: ☐ Male ☐ Female ☐ Unknown

2 -RETAIN THIS COPY FOR YOUR RECORD OF TESTS REQUESTED

ORIGINAL-LABORATORY / COPY-CLIENT

ITEM # 0072619 FORM # 0900 2pt

Test No.	Description	Specimen	CPTs	Components
Genetic Disorders				
480533	Cystic Fibrosis (32)	7mL LAV *	81220	
450020	CF*plus*® (97 mutation test)	10mL YEL	81220	
511919	Frag X, PCR w/ rflx to Southern blot analysis	10mL LAV	81243	
450010	Spinal Muscular Atrophy	10mL YEL	81329	
121690	Hgb Fractionation Cascade	1mL LAV	83020	
451950	Inheritest® Comprehensive Panel		81443, 81329, 81243	Includes more than 110 disorders including SMA,
451960	Inheritest® Society-guided Panel		81220, 81243, 81329, 81200, 81209, 81242, 81251, 81361, 81260, 81290, 81330, 81255, 81257	
451920	Inheritest® Ashkenazi Jewish Panel		81412, 81329, 81243, 81257	Cystic Fibrosis and Fragile X
451964	Inheritest® Core Panel		Please visit Labcorp.com	Includes more than 13 disorders included in ACMG and ACOG guidelines
452172	Inheritest® CF/SMA Panel		Please visit Labcorp.com	
451382	Mutation Sequence Analysis (call before sending)		81403	Includes more than 40 disorders specific to individuals of Ashkenazi descent
451385	Prenatal Mutation Specific Sequencing (call before sending)		81403	
511172	α-Thalassemia, DNA Analysis	7mL LAV *	81257	
252823	*beta* Thalassemia	2mL LAV	81364	
Pregnancy Complications				
005199	Prothrombin Time (PT)	5mL BLU	85610	
005207	PTT, Activated (APTT)	see DOS	85730	
365200	IUFD Panel	see DOS	84443, 86592, 86747 x2, 85732, 85613, 86147 x2, 85025	CBC; TSH; Human Parvovirus B19 IgG & IgM; Lupus Anticoagulant; Anticardiolipin Ab IgG, IgM; RPR
365300	IUFD Extended Panel	see DOS	81240, 81241, 83090, 84443, 86592, 86747(x2), 85300, 85303, 85306, 85732, 85613, 86147(x2), 85025	365200 plus Factor V Leiden; Factor II (Prothrombin); Antithrombin Activity; Homocysteine; Protein S Antigen, free; Protein C Activity
161802	Anticardiolipin Ab, IgG, IgM	1mL GEL	86147(x2)	
015594	Antithrombin Deficiency Profile	3mL BLU +	85300; 85301	Antithrombin Activity, Antithrombin Antigen
001610	Fibrinogen Activity	see DOS	85384	
511162	Factor II (prothrombin)	7mL LAV *	81240	
511154	Factor V Leiden	7mL LAV *	81241	
706994	Homocysteine	2mL LAV	83090	
365500	Inherited Thrombophilias of Pregnancy	see DOS	81240, 85300, 85303, 85306, 85307	Activated Protein C Resistance reflex to Factor V Leiden; Factor II (Prothrombin); Protein S Antigen, free; Protein C Activity; Antithrombin Activity
117892	Lupus Anticoagulant w Reflex	6mL BLU	85613; 85732	Lupus sensitive APTT & Dilute Russel Viper Venom Time; if prolonged, confirmation performed
511238	MTHFR	7mL LAV *	81291	
283655	Protein C Deficiency Profile	3mL BLU +	85302; 85303	Protein C, Functional, Protein C, Antigen
117754	Protein S Deficiency Profile	3mL BLU	85305; 85306(x2)	Protein S Antigen, Total, Protein S Antigen, Free, Protein S, Functional
Maternal Plasma Testing: Non Invasive Prenatal Testing (NIPT)				
451927	MaterniT21® PLUS (9w+)	MaterniT Collection Kit	81420	Please go to Labcorp.com
451931	MaterniT21® PLUS w/ ESS (9w+)	MaterniT Collection Kit	81420, 81422	Please go to Labcorp.com
451934	MaterniT21® PLUS w/ SCA (9w+)	MaterniT Collection Kit	81420	Please go to Labcorp.com
451937	MaterniT21® PLUS w/ ESS & SCA (9w+)	MaterniT Collection Kit	81420, 81422	Please go to Labcorp.com
451941	MaterniT® Genome (9w+)	MaterniT Collection Kit	81420, 81422, 81479	Please go to Labcorp.com
451951	MaterniT21® PLUS No Gender (9w+)	MaterniT Collection Kit	81420	Please go to Labcorp.com
452104	GENOME-Flex (Add On)	No collection required	81422, 81479	Please go to Labcorp.com
452114	GENOME-Flex (Add On) Redraw	MaterniT Collection Kit	81422, 81479	Please go to Labcorp.com
Maternal Serum Testing				
017500	1st Trimester Screen	3mL GEL	84163, 84702, 86336	PAPP-A, hCG, DIA
017700	Sequential Part 1	3mL GEL	84163, 84702	PAPP-A, hCG
017750	Sequential Part 2	5mL GEL	82105, 82677, 84702, 86336	AFP, uE3, hCG, DIA
017100	Integrated Part 1	3mL GEL	84163	PAPP-A
017170	Integrated Part 2	5mL GEL	82105, 82677, 84702, 86336	AFP, uE3, hCG, DIA
017200	Serum Integrated 1	3mL GEL	84163	PAPP-A
017270	Serum Integrated 2	5mL GEL	82105, 82677, 84702, 86336	AFP, uE3, hCG, DIA
017319	AFP Tetra	5mL GEL	82105, 82677, 84702, 86336	AFP, uE3, hCG, DIA
010801	msAFP	3mL GEL	82105	AFP
Cytogenetics				
511580	Chromosome & AFP/AChE/HbF	Amnio (20-30mL)	82106, 82013	
052040	Chromosome Analysis	Amnio (20-30mL)	Call CPT Coding 800-222-7566 Ext. 68400	
002428	AFP, Amniotic fluid	Amnio (2mL)	82106	
510305	AFP, AChE with reflex to HbF	Amnio (2mL)	82013, 82106	
511894	FISH, Prenatal Aneuploidy	Amnio (3-5mL)	Call CPT Coding 800-222-7566 Ext. 68400	
052104	Chromosome rfx Reveal® SNP Microarray	Amnio (20-30mL)	Call CPT Coding 800-222-7566 Ext. 68400	
511966	FISH, reflex chromosomes or Reveal® SNP Microarray	Amnio (25mL)	Call CPT Coding 800-222-7566 Ext. 68400	
511590	Chromosome Five-cell Count Plus Reveal® SNP Microarray	Amnio (25mL)	81229	
510100	SNP Microarray-Prenatal (Reveal®)	Amnio (25mL)/CVS (20-30 mg)	81229	
510200	SNP Microarray (Direct)-Prenatal (Reveal®)	Amnio (25mL)/CVS (20-30 mg)	81229	
510988	Chromosome Analysis	CVS (20-30mg)	Call CPT Coding 800-222-7566 Ext. 68400	
510960	FISH, Prenatal Aneuploidy	CVS (5mg)	Call CPT Coding 800-222-7566 Ext. 68400	
511033	Chromosome rfx Reveal® SNP Microarray	CVS (20-30mg)	Call CPT Coding 800-222-7566 Ext. 68400	
511625	FISH, reflex chromosomes or Reveal® SNP Microarray	CVS (20-30mg)	Call CPT Coding 800-222-7566 Ext. 68400	
511555	Chromosome Five-cell Count Plus Reveal® SNP Microarray	CVS (20-30mg)	81229	
052052	Chromosome, Biopsies	POC/Skin	Call CPT Coding 800-222-7566 Ext. 68400	
510110	Reveal® SNP Microarray	POC/Tissue	81229	
052065	Chromosome rfx Reveal® SNP Microarray	POC/Tissue	Call CPT Coding 800-222-7566 Ext. 68400	
511035	Chromosome, Blood	5mL GRN		
510770	FISH Microdeletion (specify)	see DOS		

Specimen

Amniotic fluid, cultured cells, or chorionic villus sample (CVS). Please submit maternal blood (sodium heparin or EDTA) for maternal cell contamination (MCC) studies. Volume 10 to 20 mL amniotic fluid, 2 T-25 flasks, or 10 to 20 mg CVS

ReproSURE™ (Ovarian Reserve Profile) Test No. 504295

When ordered as a profile CPT Codes used: 82397, 82670, 83001 ReproSURE is a blood test comprised of AMH, FSH and Estradiol hormones designed to provide information about ovarian reserve.

* Buccal swab also acceptable + Two tubes required (1/2 volume in each)

The lab only accepts isolated or extracted nucleic acids for which extraction or isolation is performed in an appropriately qualified CLIA or CAP/CMS equivalent laboratory

B-1A
ITEM # 007261 9 FORM # 09002pt
(REV 09/30/2021)