labcorp

PRECONCEPTION & PREGNANCY

0900.42

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

APPLY LABELS TO PATIENT SPECIMENS ONLY.

Patient's Legal Name (Last, First, MI) | Sex | Date of Birth | Collection Time | Fasting ☐ Yes ☐ No | Collection Date | 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

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

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)

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

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 : _____

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)

GA _____ wks _____ days on date _____ _____ _____

By ☐ LMP ☐ EDC/EDD ☐ U/S

MATERNAL PLASMA SCREENING: NONINVASIVE PRENATAL SCREENING (NIPS)

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

Indication for Noninvasive Prenatal Screening (NIPS)

☐ 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 WITH NT

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

CRL date _____ _____ _____ *Twin B, if applicable*

CRL _____ . _____ mm (45.0-84.0)

CRL _____ . _____ mm (45.0-84.0)

NT _____ . _____ mm Chorionicity: ☐ Mono ☐ DI ☐ Unknown

NT _____ . _____ mm

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 ☐ Not Evaluated ☐ 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.

CYTOGENETICS

Amniotic Fluid (specify GA below)

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

Chorionic Villi (specify GA below)

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

POC / Tissue / Other (specify GA below)

052052	☐	Chromosome Analysis
510110	☐	SNP Microarray - POC Tissue (Reveal®)
511997	☐	SNP Microarray - POC FFPE (Reveal®)
052065	☐	Chromosome rflx Reveal® SNP Microarray
511035	☐	Chromosome, Blood
510770	☐	FISH Microdeletion (Specify)

Fetal Sex: ☐ Male ☐ Female ☐ Unknown

By: ☐ U/S ☐ NIPS ☐ PGT

Gestational age: _____

☐ Hold cells

511402 ☐ Maternal cell contamination (mat blood required)

Clin Info, Fam Hx, Other _____

Abnl NIPS: Specify _____

CARRIER SCREENING

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
482370	☐	Geneseq PLUS ☐ VUS opt out

Required: Gene(s) _____

480533	☐	Cystic Fibrosis (32)
450020	☐	CF*plus*® (97 mutation test)
511919	☐	Fragile X Syndrome, Carrier
481630	☐	Spinal Muscular Atrophy (SMA), Carrier Testing
511172	☐	α-Thalassemia, DNA Analysis
252823	☐	β-Thalassemia: *HBB* (Full Gene Sequencing)
121690	☐	Hgb Fractionation Cascade

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.

PREGNANCY COMPLICATIONS

005199	☐	Prothrombin Time (PT)
005207	☐	PTT, Activated (APTT)
161802	☐	Anticardiolipin Ab, IgG, IgM
015594	☐	Antithrombin Deficiency Profile
001610	☐	Fibrinogen Activity
511162	☐	Factor II (Prothrombin)
511154	☐	Factor V Leiden
706994	☐	Homocysteine
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
502051	☐	Recurrent Miscarriage
504808	☐	Von Willebrand Reflexive

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

1-FORWARD TO LABCORP WITH SPECIMEN-RETAIN LAST COPY

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TEST COMBINATION/PANEL POLICY

Labcorp's policy is to provide physicians, in each instance, with the flexibility to choose appropriate tests to assure that the convenience of ordering test combinations/panels does not distance physicians who wish to order a test combination/profile from making deliberate decisions regarding which tests are truly medically necessary. All the tests offered in test combinations/panels may be ordered individually using the Labcorp® request form. Labcorp encourages clients to contact their local Labcorp representative or Labcorp location if the testing configurations shown here do not meet individual needs for any reason, or if some other combination of procedures is desired.

In an effort to keep our clients fully informed of the content, charges and coding of its test combinations/panels when billed to Medicare, we periodically send notices concerning customized test combinations/panels, as well as information regarding patient fees for all Labcorp services. We also welcome the opportunity to provide, on request, additional information in connection with our testing services and the manner in which they are billed to physicians, health care plans, and patients.

For CPT codes please contact the CPT coding department at telephone number 800-222-7566 ext 6-8400 or www.labcorp.com. Please note, correct coding often varies from one carrier to another. Consequently, the codes provided by Labcorp are intended as general guidelines and should not be used without confirming with the appropriate payor that their use is appropriate in each case. All laboratory procedures will be billed to third-party carriers (including Medicare and Medicaid) at fees billed to patients and in accordance with the specific CPT coding required by the carrier. Microbiology CPT code(s) for additional procedures such as susceptibility testing, identification, serotyping, etc. will be billed in addition to the primary codes when appropriate. Labcorp will process the specimen for a microbiology test based on source.

(REV 09/08/2022)