labcorp

PREECLAMPSIA

1800.02

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 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

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

REQUIRED INFORMATION

Patient Weight _____ lbs OR _____ kg
Patient Height _____ in or _____ cm
# of Fetuses ☐1 ☐2 ☐Other _____
Patient Race ☐Cauc ☐Hispanic ☐Black ☐Asian ☐Amer Indian ☐Other
☐Yes ☐No Is patient a diabetic?
☐Yes ☐No Is patient an insulin dependent diabetic?
BP Measurements: Left Arm1 _____ mmHg Right Arm1: _____ mmHg
OR Left Arm2 _____ mmHg Right Arm2: _____ mmHg
Mean Arterial Pressure (MAP): _____ mmHg

If used, what method of assistance was used?
☐IVF ☐GIFT ☐ZIF ☐Clomifene Tx ☐Donor Egg ☐Donor Insemination ☐ICSI ☐Other
Past number of Pregnancies lasting >24 weeks?_____
Gestational Age of Previous Pregnancy? _____

☐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 Previous pregnancy with Down Syndrome?
☐Yes ☐No Previously Diagnosed with Preeclampsia?
☐Yes ☐No Family History of Preeclampsia?
☐Yes ☐No Chronic Hypertension Diagnosis?
☐Yes ☐No Systemic Lupus Erythematosus diagnosis?
☐Yes ☐No Is this patient currently smoking?
☐Yes ☐No Antiphospholipid syndrome diagnosis?
☐Yes ☐No Other Indications : _____

PREECLAMPSIA SCREENING

486230 ☐ **1st. Trimester Preeclampsia screen**
486226 ☐ **2nd./3rd. Trimester Preeclampsia test**

GA _____ wks _____ days on date _____/_____/_____
By ☐LMP ☐EDC/EDD ☐U/S LMP/EDD Date: _____

SONOGRAPHER INFORMATION

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 Uterine Artery Pulsatility (UtAPI): _____
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.

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

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Physician's Name (Last, First) | Physician/Authorized Signature X _____ | Genetic Counselor (Last, First)

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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

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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.