sequenom

PRENATAL TEST REQUEST FORM

877.821.7266

sequenom.com | Mon–Fri 5 am–5 pm PST
3595 John Hopkins Ct San Diego, CA 92121
CLIA# 05D2015356 | CAP# 7527138

PLACE BARCODED PATIENT ID LABEL HERE

Sample collection date: ____/____/_____

PATIENT INFORMATION AND ACKNOWLEDGMENT & PHYSICIAN ACKNOWLEDGMENT

Last name: _____ First name: _____ DOB: ____/____/_____ Sex: ☐ Male ☐ Female

Street address: _____ City / State / ZIP: _____

Phone: (_____) _____ – _____ Email: _____ MRN (optional): _____

Sequenom Laboratories may use information obtained on this form and other information provided by the patient and/or ordering provider or his/her designee to initiate preauthorization with the patient's health plan as required. Pretest counseling has occurred with the patient in accordance with patient's health plan requirements if applicable. The patient understands a preauthorization approval from their health plan does not guarantee full payment and the patient accepts financial responsibility for any amounts not covered by their health plan. If applicable, patient authorizes Sequenom Laboratories to appeal any coverage denial made by carrier on patient's behalf.

Patient's signature: _____ Date :____/____/_____

I attest that this patient has been informed about and has given consent for the test(s) I have ordered below under applicable law.

Physician/authorized signature: _____ Date :____/____/_____

Sequenom Laboratories is required by law to maintain the privacy and security of your protected health information in accordance with its notice of privacy practices (www.sequenom.com/notice-patient-privacy-practices).

CLINICIAN INFORMATION

Sequenom lab account #: _____

Account name: _____

Account address: _____

City / State / ZIP: _____

Ordering physician: _____ NPI #: _____

Phone: (_____) _____ – _____ Fax: (_____) _____ – _____

ADDITIONAL COPY OF RESULTS *(optional)*

Referring clinician: _____ Fax: (_____) _____–_____

Other clinical recipient: _____ Fax: (_____) _____–_____

NONINVASIVE PRENATAL TEST (NIPT) MENU – *select only one test*

MaterniT® 21 PLUS
Select fetal aneuploidies
Choose one option:

☐ Core (chr 21, 18, 13, sex)
☐ Core + ESS*
☐ Core + SCA**
☐ Core + ESS* + SCA**

OR

☐ **MaterniT® GENOME**
Genome-wide fetal aneuploidies (singleton only)

☐ **GENOME-Flex**
Specimen re-sequencing after MaterniT 21 PLUS, please contact Client Services

☐ Fetal Sex opt-out - MaterniT 21 PLUS or MaterniT GENOME

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

REQUIRED CLINICAL INFORMATION

Gestational age: _____ weeks _____ days *or* EDD: ____/____/_____

Gestation: ☐ Singleton ☐ Twins ☐ Triplets ☐ Other: _____

Maternal height: _____ ft. _____ in. Maternal weight: _____ lbs.

Patient race: ☐ Caucasian ☐ Hispanic ☐ Black ☐ Asian ☐ American Indian ☐ Other: _____

☐ Yes ☐ No Is patient an insulin dependent diabetic?

☐ Yes ☐ No Egg donor: ☐ Self ☐ Non-self Age of donor at egg retrieval_____

MEDICAL INDICATION(S) FOR GENETIC TESTING

Diagnosis/signs/symptoms in ICD-CM format in effect at date of service (highest specificity required)

Medical indication for testing

☐ Advanced maternal age (ICD-CM: _____)
☐ Positive serum screening (ICD-CM: _____)
☐ Ultrasound findings indicate increased risk (ICD-CM: _____)
☐ Prior pregnancy with trisomy (ICD-CM: _____)
☐ Parental balanced Robertsonian translocation with increased risk of trisomy (ICD-CM: _____)
☐ Family history of NTD (ICD-CM: _____)
☐ Parental cytogenetics following abnormal prenatal results (ICD-CM: _____)
☐ No known high risk for fetal chromosomal aneuploidies (ICD-CM: _____)
☐ Other (ICD-CM: _____)

Preauthorization question

☐ Cell-free DNA testing previously performed during this pregnancy

BILLING INFORMATION *Attach copy of both sides of insurance card if applicable*

Bill: ☐ Patient (self pay) ☐ Insurance (direct bill) ☐ Client bill

Policyholder name: _____

Patient relationship to policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policyholder date of birth: ____/____/_____

Insurance company name: _____

Billing address: _____

City / State / ZIP: _____

Policy/Medicaid #: _____ Group #: _____

Authorization #: _____

COMMENTS

MATERNIT® 21 PLUS ORDERING OPTIONS

The core MaterniT 21 PLUS test includes T21, T18, T13 and fetal sex. Please select desired content on the other side of this form.

SEX CHROMOSOME ANEUPLOIDIES OPTION
Includes sex chromosome aneuploidies. See list below.

MICRODELETIONS/ENHANCED SEQUENCING SERIES (ESS) OPTION
Includes T22, T16, and selected microdeletions (Enhanced Sequencing Series). See list to the right.

* Reported as additional findings

MATERNIT 21 PLUS TEST
Trisomy 21 (Down syndrome)
Trisomy 18 (Edwards syndrome)
Trisomy 13 (Patau syndrome)
Fetal sex

SEX CHROMOSOME ANEUPLOIDIES*
45,X (Turner syndrome)
47,XXY (Klinefelter syndrome)
47,XXX (Triple X syndrome)
47,XYY (XYY syndrome)

MICRODELETIONS (ESS)*
22q (DiGeorge syndrome)
5p (Cri-du-chat syndrome)
1p36 deletion syndrome
15q (Angelman/Prader-Willi syndromes)
11q (Jacobsen syndrome)
8q (Langer-Giedion syndrome)
4p (Wolf-Hirschhorn syndrome)
Trisomy 22
Trisomy 16

ADDITIONAL INFORMATION

Sequenom Center for Molecular Medicine, LLC, DBA Sequenom Laboratories, a wholly owned subsidiary of Sequenom, Inc., is a CAP-accredited and Clinical Laboratory Improvement Amendment (CLIA)-certified molecular diagnostics laboratory dedicated to improving patient outcomes by offering revolutionary laboratory-developed tests for a variety of prenatal conditions. Sequenom, Inc. is a wholly owned subsidiary of Laboratory Corporation of America Holdings.