sequenom
PRENATAL TEST REQUISITION FORM

877.821.7266
Mon–Fri 5am–5pm PST

3595 John Hopkins Ct
San Diego, CA 92121
CLIA# 05D2015356
CAP# 7527138

RML
REGIONAL MEDICAL LABORATORY
www.RMLOnline.com

PLACE BARCODED PATIENT ID LABEL HERE

Sample collection date: ___ / ___ / ___

PATIENT INFORMATION AND ACKNOWLEDGEMENT & PHYSICIAN ACKNOWLEDGEMENT

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

Street address: _____ City / State / ZIP: _____

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

My healthcare provider has informed me about the test(s) requested on this form and the availability of genetic counseling. If the Insurance box is marked in the Billing Information section, I authorize Regional Medical Laboratory (or Sequenom Laboratories if MaterniT GENOME, MaterniT 21 PLUS no known high risk, or VisibiliT are selected, or my insurance is through Aetna, Medicaid or Managed Care Medicaid) to share with my designated insurance carrier the information on this form, my test results and other information requested by my carrier for coverage. I authorize payment of my insurance benefits to Regional Medical Laboratory (or Sequenom Laboratories if MaterniT GENOME, MaterniT 21 PLUS no known high risk, or VisibiliT are selected, or my insurance is through Aetna, Medicaid or Managed Care Medicaid). If insurance payment is sent to me, I will promptly endorse and forward the payment to Regional Medical Laboratory (or Sequenom Laboratories if MaterniT GENOME, MaterniT 21 PLUS no known high risk, or VisibiliT are selected, or my insurance is through Aetna, Medicaid or Managed Care Medicaid). If applicable, I authorize Regional Medical Laboratory (or Sequenom Laboratories if MaterniT GENOME, MaterniT 21 PLUS no known high risk, or VisibiliT are selected, or my insurance is through Aetna, Medicaid or Managed Care Medicaid) to appeal any coverage denial made by my carrier on my behalf. This test will not be covered if it falls outside of my insurance carrier's medical and coverage guidelines.

Patient's signature: _____ Date: ___ / ___ / _____ Physician/authorized signature: _____ Date: ___ / ___ / _____

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

CLINICIAN INFORMATION

ADDITIONAL COPY OF RESULTS *(optional)*

Referring clinician: _____ Fax: (_____) _____-_____

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

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

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

Policyholder name: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policyholder date of birth: ___ / ___ / _____

Insurance company name: _____

Billing address: _____

City / State / ZIP: _____

Policy / Medicaid #: _____ Group #: _____

Authorization #: _____ No out-of-pocket costs for covered services for Medicaid patients

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

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

OR

MaterniT® 21 PLUS
Select fetal aneuploidies
Choose one option:
☐ Core (chr 21, 18, 13, sex)
☐ Core + ESS*
☐ Core + SCA**
☐ Core + ESS + SCA

OR

☐ **VisibiliT™**
Risk assessment for fetal aneuploidies for chromosomes 21 & 18, and fetal sex
(singleton only)

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

REQUIRED CLINICAL INFORMATION

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

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

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

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: _____)
☐ Routine screening (MaterniT 21 PLUS or VisibiliT only) (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

COMMENTS