INVITAE

ORDER ID
For Invitae internal use only

INVITAE PREGNANCY LOSS REQUISITION FORM

PATIENT INFORMATION

First name | MI | Last name | Date of birth (MM/DD/YYYY) | Biological sex ○ Male ○ Female | MRN (medical record number)

Email address | Mobile phone | Ancestry: ○ Asian ○ Black/African American ○ White/Caucasian ○ Ashkenazi Jewish ○ Hispanic ○ Native American ○ Pacific Islander ○ French Canadian ○ Sephardic Jewish ○ Mediterranean ○ Other: ____

Address | City | State/Prov | Zip/Postal code | Country

ORGANIZATION INFORMATION

Organization name | Phone | Fax

Address | City | State/Prov | Zip/Postal code | Country

Primary clinical contact name (contact for general inquiries) | Phone | Fax | Email address

Ordering physician name | NPI | Phone | Fax | Email address

Referring physician name | Phone | Fax | Email address

Additional clinical or laboratory contact name | Fax | Email address

INSURANCE BILLING (attach front and back of insurance card)

Attach applicable clinical notes and medical records. We do not accept insurance for patients outside the US. www.invitae.com/billing

Policyholder name | Patient relationship to policyholder ○ Self ○ Spouse ○ Child ○ Other: ____ | Indicate ICD-10 code in Reason for testing

Primary insurance company name | Primary member ID # | Primary insurance phone | Prior-authorization #

Secondary insurance company name | Secondary member ID # | Secondary insurance phone | Prior-authorization #

PATIENT PAY BILLING

Invitae will send an electronic invoice to the patient email address listed above.

INSTITUTIONAL BILLING

Invitae will send an invoice to the organization listed above.

Collection date: ____/____/____ **# tubes:** ____ **Specimen ID#s:** ____

PREGNANCY LOSS

MISCARRIAGE ANALYSIS

○ Invitae Pregnancy Loss Chromosomal Microarray Analysis

Specimen type:
○ Fresh tissue ○ FFPE block ○ Amniotic fluid ○ Cultured amniocytes
○ Chorionic villi ○ Cultured CVS ○ Cultured fetal cells
○ DNA source: ____

Reason for testing (select all that apply):
○ N96 Recurrent pregnancy loss
○ Z33.2 Therapeutic abortion
○ Z37.1 Stillbirth
○ Other ICD-10: ____
○ O36.4XX1 Intrauterine fetal demise >20 weeks
○ O02.1 Missed abortion
○ O03.9 Miscarriage/spontaneous abortion

Patient's pregnancy history:
Gravida ____ Para ____ SABs ____ TABs ____

This pregnancy's history:
Gestational age: Wks ____ Days ____ ○ Unknown
How many fetuses? ○ 1 ○ 2 ○ 3
Fetal sex: ○ Female ○ Male ○ Unknown
Fetal karyotype: ○ 46,XX ○ 46,XY ○ Not performed ○ Pending ○ Abnormal*
NIPS results: ○ Not performed ○ Normal ○ Abnormal* *enclose copy of report

If NIPS was performed at Invitae, provide Order ID: RQ ____

Provide additional info regarding any fetal anomalies:

Special instructions/additional requests:

PARENTAL FOLLOW-UP

○ Invitae Parental Chromosomal Microarray Analysis
○ Invitae Parental FISH Analysis
○ Invitae Parental Karyotype (Chromosome Analysis)

Specimen type: Blood
4-mL purple EDTA and
4-mL green NaHep tubes

Previous testing:
○ Previous testing was performed at Invitae/Combimatrix - provide previously tested info:
Invitae accession#: ____ Relationship to patient: ____
Full name: ____ DOB: ____
○ Previous testing was performed at another lab:
○ Report is available - include copy with sample shipment
○ Report is not available - call Invitae Genetic counseling 800-436-3037 to confirm testing

Reason for testing (select all that apply):
Evaluation of genetic disease carrier status for procreative management ○ Z31.430 Female ○ Z31.440 Male
○ Z82.79 Family history of a chromosome abnormality ○ Other ICD-10: ____

RECURRENT PREGNANCY LOSS OR INFERTILITY

○ Invitae Reproductive Karyotype (Chromosome Analysis)

Specimen type: Blood
4-mL purple EDTA and 4-mL green NaHep tubes

Reason for testing (select all that apply):
○ N97.9 Female infertility, unspecified ○ N96 Female recurrent pregnancy loss
○ N46.9 Male infertility, unspecified ○ Z31.441 Male partner of patient with recurrent pregnancy loss

By signing this form, the medical professional acknowledges that the individual/family member authorized to make decisions for the individual (collectively, the "Patient") has been supplied information regarding and consented to undergo genetic testing, substantially as set forth in Invitae's Informed Consent for Genetic Testing (www.invitae.com/cytogenomic-consent), has been informed that Invitae may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional as indicated), and for orders originating outside the US, has been informed that the Patient's personal information and specimen will be transferred to and processed in the US. The Patient has further been informed and authorizes Invitae Corporation ("Invitae") and its designees to release information concerning testing to their insurer, if applicable, in order to process and/or appeal claims on behalf of the Patient. If a letter of medical necessity (LMN) has not been provided, the medical professional agrees to allow Invitae to transfer the information from this requisition to a LMN and/or other documentation using the medical professional's name as the signature for insurance billing. For amounts received directly, the Patient has agreed to remit payment to Invitae for testing services rendered. I acknowledge that the Patient has agreed that if the Patient's insurer does not reimburse Invitae in full for any reason, including if the insurer considers the genetic test ordered to be a non-covered service or not medically necessary, then Invitae may bill the Patient directly for the services and the Patient will remit payment directly to Invitae. I acknowledge that I offered pre-test genetic counseling to the Patient, if required by their insurer. In addition to the above, I attest that I am the ordering physician, or I am authorized by the ordering physician to order this test, or I am authorized under applicable law to order this test.

Medical professional signature (required) | **Date**

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