

# PRENATAL REQUISITION FORM



## Page 1 of 2

Please complete all information below.  
Failure to do so may delay sample processing.  
We accept samples Monday through Saturday.

2820 North Astor Street, Spokane, WA 99207  
Phone: 509.474.6840 / Fax: 509.474.6839  
TOLL FREE 1.877.SigChip (744.2447)  
www.signaturegenomics.com / info@signaturegenomics.com

### INFORMED CONSENT REQUIRED

NOTE TO HEALTH CARE PROVIDERS: Signature Genomics recognizes that it is important for physicians to discuss pertinent information about genetic testing with their patients. In accordance with Washington State Law RCW 7.70.050 and WAC 388-531-0050, the physician referring the patient for laboratory testing is responsible for informing the patient of the risks and benefits of the laboratory testing and obtaining the patient's informed consent. As a courtesy to our ordering health care providers and their patients, we offer educational literature including *Points to Consider*, *Frequently Asked Questions for Physicians*, *Frequently Asked Questions for Prenatal Testing* and *Informed Consent for Molecular Cytogenetic Testing* to assist in discussions of the benefits and limitations of array CGH testing. To obtain copies of these documents and other helpful resources, please visit our website at [www.signaturegenomics.com](http://www.signaturegenomics.com) or contact us directly at 1.877.SigChip (1.877.744.2447).

By signing below, I attest that I have obtained informed consent for the test(s) that I have ordered below through Signature Genomics from this patient and/or guardian(s).

PHYSICIAN SIGNATURE: \_\_\_\_\_ *Required for samples originating in New York*

### PATIENT INFORMATION

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (mm dd yyyy)     Male     Female  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_  
Specimen # / ID # \_\_\_\_\_

### PREGNANCY INFORMATION

I. Is this an on-going pregnancy?     Yes     No  
II. Fetal Sex (required for accurate analysis)     Male     Female     Unknown  
III. Karyotype     Normal     Abnormal     Pending     Not Performed  
Details \_\_\_\_\_ (attach report)  
IV. Weeks Gestation \_\_\_\_\_     by LMP \_\_\_\_\_     by Ultrasound on \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### INDICATION FOR STUDY (IFS)

I. Check all that apply and attach or provide additional details below  
 Abnormal maternal serum screen     Family history  
 Abnormal ultrasound     Parental concern  
 Advanced maternal age     Other

Provide additional details \_\_\_\_\_

II. ICD-9 code (required for insurance billing) \_\_\_\_\_

### PRENATAL SAMPLE TEST REQUESTED

Signature PrenatalChip® (Targeted)  
 SignatureChipWG™ (Whole Genome)  
 SignatureChipOS™ (Oligo Solution)  
 Single/Dual FISH: Contact Signature Genomics to discuss case.  
 Karyotype (Note: If karyotype is not requested it should be performed elsewhere for all prenatal specimens)

#### Amniotic fluid only (choose one):

AFP only     AChE only     AFP & AChE     AFP w/reflex to AChE

#### Maternal Cell Contamination Studies

Signature Genomics strongly recommends that MCC testing be performed on each prenatal sample that is received. If MCC is pending or has already been performed at a different laboratory, please check this box  and forward test results. Note that performing MCC studies on a different sample from the same source is not enough to rule out MCC. There is an additional charge for MCC studies. Requires 3-5cc maternal blood.

Proceed with MCC     Decline MCC

### PARENTS' SAMPLES

Check one. Please note that charges may apply.

Fetal sample to accompany or follow.  
 Fetal analysis complete. Perform follow-up analysis on parental sample(s). If Signature Genomics is to bill a new insurance, please fill out page 2 of this form.

Sample(s) included in this shipment:

**Mother**  
Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Sample Type     Blood     DNA     other \_\_\_\_\_  
 **Father**  
Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Sample Type     Blood     DNA     other \_\_\_\_\_

### REFERRING PHYSICIAN

Name \_\_\_\_\_  
NPI# \_\_\_\_\_ Specialty \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Hospital/Institution \_\_\_\_\_  
Tel (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_  
Counselor/Contact \_\_\_\_\_  
Tel (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
E-mail \_\_\_\_\_  
**Additional Reports To:**  
Name \_\_\_\_\_  
Hospital/Institution \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Tel (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

### SAMPLE INFORMATION

Indicate the reference lab sending sample to Signature Genomics:

Date Sample Obtained \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (mm dd yyyy)

#### CVS

Cultured cells

#### AMNIOCENTESIS

Direct fluid     Cultured cells

#### PRODUCTS OF CONCEPTION

Specify tissue of origin \_\_\_\_\_  
 Cultured cells     Direct specimen

#### BLOOD

Fetal, specify source:     PUBS     Cord blood – post delivery

**DNA** Please read *DNA Acceptance Policy* at [www.signaturegenomics.com](http://www.signaturegenomics.com)

Specify DNA source:    direct    cultured

CVS	<input type="checkbox"/>	<input type="checkbox"/>
Amnio	<input type="checkbox"/>	<input type="checkbox"/>
Tissue	<input type="checkbox"/>	<input type="checkbox"/>
Blood (PUBS)	<input type="checkbox"/>	<input type="checkbox"/>
Blood (cord)	<input type="checkbox"/>	<input type="checkbox"/>

#### OTHER

Please specify \_\_\_\_\_

#### Specimen Requirements

**Cultured cells:** 1x T-75 flask or 3x T-25 flasks, 70% confluent

**Direct amniotic fluid:** 15-20cc

**Tissue/POC:** 15-20 mg tissue in sterile media or saline

**Fetal blood:** Minimum 1cc in NaHep

**Parental Blood:** 2 tubes, 1x 3-5cc EDTA and 1x 3-5cc NaHep

*Additional costs may be incurred if specimen quality or quantity is suboptimal.*

### USE OF SPECIMENS

Signature Genomics (SG) retains patient samples indefinitely for validation, educational purposes and/or research, maintaining the confidentiality of each sample. Patients may decline the use of submitted sample(s) for research; refusal does not impact diagnostic testing or reporting of results. Patients may withdraw consent for use of sample(s) at any time by contacting the SG Chief Medical Officer at (509) 474-6840. SG will not pay royalties to patients if a commercial product is developed during research using their samples. I do not wish to allow my (or my fetus's) sample to be used for test validation or education. Therefore, I am checking this box  to indicate that the sample should be used for the test specified above and will be destroyed after 60 days.

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### PATIENT INFORMATION

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm dd yyyy)  
Name \_\_\_\_\_  
Last First

### INSTITUTIONAL BILLING

P.O. \_\_\_\_\_  
Client ID \_\_\_\_\_  
Institution Name \_\_\_\_\_  
Financial Contact \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
TEL (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_

### SELF-PAY

- Check or Money Order  Credit Card  
 Send receipt to patient address on Page 1

Payment will not be processed before sample arrives. This is to ensure that the correct amount is charged to the credit card.

**Check one:**  AMEX  Visa  MC  Discover

Acct # \_\_\_\_\_ Exp Date \_\_\_\_/\_\_\_\_  
(mm yyyy)

Zip Code \_\_\_\_\_ 3 or 4 Digit Security Code \_\_\_\_\_

Print Name as it appears on card \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(mm dd yyyy)

A new authorization and/or signature may be required when testing additional family members.

### REQUEST FOR SIGNATURE GENOMICS TO DIRECTLY BILL PATIENT'S INSURANCE

**IMPORTANT:** Patients and health care providers requesting that Signature Genomics bill private insurance must complete this portion of the requisition form prior to or at the time of sample submission. **Failure to do so will delay testing and results.**

I have obtained prior authorization.

CPT codes and units authorized: \_\_\_\_\_

Prior-Authorization #: \_\_\_\_\_

As a courtesy service, Signature Genomics will obtain benefit information from the patient's insurance. If a benefit investigation and/or prior authorization is requested prior to sample submission, complete and fax both page 1 and page 2 of this requisition form to 509.474.6839. This information may also be submitted with the sample. Please include a Letter of Medical Necessity and clinic notes as this information may be required by the insurance company for prior authorization. For benefit investigation of parents' sample(s), please complete an additional billing page if one parent's insurance differs from the proband's insurance.

Whom should our billing specialist contact in order to communicate benefit information?  
CHECK ALL THAT APPLY (REQUIRED):  Patient  Physician  Genetic Counselor/Contact

### INSURANCE INFORMATION **Include enlarged copy of insurance card/s (front and back)**

If your institution's intake form addresses all items below, you may attach it. Otherwise, please fill in each item completely.

Is this a Medicaid Policy?  Yes  No

Insurance Company Name \_\_\_\_\_

Policyholder's Name \_\_\_\_\_  
Last First M.I.

Insurance Company Phone \_\_\_\_\_

SSN \_\_\_\_\_

Plan Name \_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

ID# \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Group# \_\_\_\_\_

If HMO, provide PCP Name \_\_\_\_\_

### AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR MY ACCOUNT

I assign and authorize insurance payments to Signature Genomics. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity or otherwise. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State and Federal law. A duplicate or faxed copy of this authorization is considered same as the original document.

### AUTHORIZATION TO CONTACT HEALTH INSURANCE CARRIER AND RELEASE CONFIDENTIAL MEDICAL INFORMATION

I understand Signature Genomics will contact my insurance carrier regarding coverage of genetic testing. I authorize the disclosure of insurance benefit coverage and payment information to Signature Genomics. I authorize my physician or other medical entity to release confidential medical information to Signature Genomics concerning my medical history. I authorize Signature Genomics to release confidential medical information to my health insurance carrier to facilitate reimbursement of my medical fees.

Check this box to hold testing until investigation of benefits / prior authorization is complete.  
If this box is not checked, analysis will proceed upon sample receipt.

Signature of Patient or Guardian

Printed Name of Patient or Guardian

Date

### PATIENT FINANCIAL ASSISTANCE

**FINANCIAL ASSISTANCE INFORMATION.** For more information, visit our website at [www.signaturegenomics.com](http://www.signaturegenomics.com).

Household size (e.g. number of people): \_\_\_\_\_ Household income (monthly): \_\_\_\_\_

By signing below, I certify that the household size and income information shown above is correct. Copies of tax returns, pay stubs and other information verifying income may be required before a discount is applied.

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Please fax completed forms to **509.474.6839** and include in sample shipment.