

# PRENATAL REQUISITION FORM



## Page 1 of 2: Case Information

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  
TEL 509.474.6840 / FAX 509.474.6839  
TOLL FREE 1.877.SigChip (744.2447)  
www.signaturegenomics.com / info@signaturegenomics.com

### 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. Date of U/S: \_\_\_\_/\_\_\_\_/\_\_\_\_ GA on date of U/S: \_\_\_\_ wks \_\_\_\_ days  
Date of LMP: \_\_\_\_/\_\_\_\_/\_\_\_\_ GA by LMP: \_\_\_\_ wks \_\_\_\_ days

### 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

Check this box to request that Signature Genomics (SG) stabilize the prenatal sample and HOLD analysis until an authorized health care provider (MUST be listed on this form) contacts SG to proceed. (e.g. SG will hold a sample until karyotyping is complete at a separate non-SG lab.)

**Signature Precision Panel™ | Prenatal**  
 Signature Precision Panel™ | Prenatal, only  
 Signature Precision Panel™ | Prenatal, **plus karyotyping** (simultaneous)  
 Karyotyping. If normal, proceed with Signature Precision Panel™ | Prenatal  
Maternal Cell Contamination (MCC) Studies\*:  Proceed  Decline  
(Requires 3-5cc maternal blood in EDTA)

**Array CGH / microarray options**  
 Signature PrenatalChip@OS (High Density)  
 Signature PrenatalChip@TE (Targeted Enhanced)  
 Karyotyping. If normal, proceed with Signature PrenatalChip@  OS  TE  
Maternal Cell Contamination (MCC) Studies\*:  Proceed  Decline  
(Requires 3-5cc maternal blood in EDTA)

### Other testing available at Signature Genomics:

FISH (contact SG to discuss case)  
 Karyotype Only  
 Parental studies. Name/SG# of patient: \_\_\_\_\_  
For amniotic fluid only:  
 AFP  AChE only  AFP & AChE  AFP w/ reflex to AChE

\* 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.

### PARENTS' SAMPLES

DIRECTIONS FOR SENDING PARENTAL SAMPLES:  
• Fill out top of this form with pregnant patient's information.  
• In the space below, document the mother's and/ or father's information.  
Check one. Please note that charges may apply.  
 Fetal sample is included in this shipment.  
 Fetal sample will follow on \_\_\_\_ (date, can be approximate)  
 Submitted after fetal analysis, due to abnormal result.  
Sample(s) included in this shipment:  
 **Mother:** Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Sample Type  Blood  DNA  other \_\_\_\_\_  
Date Sample Obtained \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm dd yyyy)  
If insurance is to be billed for this parent's testing, obtain signatures on page 2.  
 **Father:** Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Sample Type  Blood  DNA  other \_\_\_\_\_  
Date Sample Obtained \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm dd yyyy)  
If insurance is to be billed for this parent's testing, obtain signatures on page 2.

### REFERRING PHYSICIAN

Name \_\_\_\_\_  
NPI# \_\_\_\_\_ Specialty \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Hospital/Institution \_\_\_\_\_  
Tel (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_  
Clinical 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:

Lab Contact: \_\_\_\_\_ Tel (\_\_\_\_) \_\_\_\_\_  
Date Sample Obtained \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm dd yyyy)  
Will a backup sample be maintained?  Yes  No

**CVS**  
 Direct CVS  Cultured cells

**AMNIOCENTESIS**  
 Direct fluid  Cultured cells

#### PRODUCTS OF CONCEPTION

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

**BLOOD**  
 Fetal, specify source:  PUBS  Cord blood – post delivery

**DNA** Please read DNA Acceptance Policy at 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 CVS:** 5–10mg for microarray, 15–30mg for Precision Panel™ plus Karyotype.  
**Direct amniotic fluid:** 15–20cc for microarray or for Precision Panel™ plus Karyotype.  
**Tissue/POC:** 15–20mg 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. To ensure patient confidentiality, SG removes all patient identifying information from samples before they are used for research or other such purposes. 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 (unless sample has been completely de-identified for research purposes) by contacting the SG Chief Medical Officer at (509) 474-6840. SG will not pay compensation to patients if a commercial product is developed during research using their samples. I do not wish to allow my (or my fetus') 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.

# PRENATAL REQUISITION FORM



## Page 2 of 2: Billing Information

Please complete all information below.  
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### PATIENT INFORMATION

The Billing Information page is required for each case received.  
Parental sample?  No  Yes.\* Proband's Name: \_\_\_\_\_  
\* If yes, complete a Billing Information page (this page, 2 of 2) specific to the parent.  
The billing information supplied on this page corresponds to the patient listed below:  
DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 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

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

**Note: The patient's or guardian's signature is required by law to authorize Signature Genomics to contact the patient's insurance company to investigate insurance benefits.**  
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 (Required) \_\_\_\_\_ Printed Name of Patient or Guardian (Required) \_\_\_\_\_ Date (Required) \_\_\_\_\_

### 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 \_\_\_\_\_ Insurance Company Phone \_\_\_\_\_  
Last First M.I. Plan Name \_\_\_\_\_  
SSN \_\_\_\_\_ ID# \_\_\_\_\_  
Policyholder's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Group# \_\_\_\_\_  
mm dd yyyy If HMO, provide PCP Name \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

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

**Note: Signature Genomics cannot proceed with testing of the sample on insurance bill cases without a signature below.**  
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.  
Signature of Patient or Guardian (Required) \_\_\_\_\_ Printed Name of Patient or Guardian (Required) \_\_\_\_\_ Date (Required) \_\_\_\_\_

### PATIENT FINANCIAL ASSISTANCE

**FINANCIAL ASSISTANCE INFORMATION.** For more information, visit our website at 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.