

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

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 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@OS (High Density)
 Signature PrenatalChip@TE (Targeted Enhanced)
 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

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 _____
If insurance is to be billed for this parent's testing, obtain signatures on page 2.

Father

Name _____ DOB ____ / ____ / ____

Sample Type Blood DNA other _____
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 (____) _____
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

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

Direct amniotic fluid for microarray only: 12-15ml*

*additional material is required if karyotype is desired.

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. 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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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.