INVITAE

ORDER ONLINE at www.invitae.com/signin.

ORDER ID
For Invitae internal use only

INVITAE REQUISITION FORM

PATIENT INFORMATION

First name | MI | Last name | Date of birth (MM/DD/YYYY)

Sex: ○ M ○ F

MRN (medical record number)

Ancestry: ○ Asian ○ Black/African American ○ White/Caucasian ○ Ashkenazi Jewish ○ Hispanic ○ Native American ○ Pacific Islander ○ French Canadian ○ Sephardic Jewish ○ Mediterranean ○ Other: _____

Email address (for report access after release by medical professional) | Phone

Address

City | State | ZIP code | Country

ORGANIZATION INFORMATION

Organization name and address

Organization name			Phone
Address			Fax
City	State	ZIP code	Country

Primary clinical contact

Name	NPI
Email address (for report access)	Phone

Ordering physician

○ **Same as primary clinical contact**

Name	NPI
Email address (for report access)	Phone

Additional clinical or laboratory contacts (optional)

Name	Email address (for report access)	Name	Email address (for report access)
Name	Email address (for report access)	Name	Email address (for report access)

○ INSURANCE BILLING (Please attach a copy of the patient's card.)

We do not accept insurance for certain tests *or* patients outside the US. Before completing this section, confirm your test is eligible at www.invitae.com/billing.

Primary insurance company name	Primary member ID#
Secondary insurance company name	Secondary member ID#
○ Patient has Medicare and was treated as a hospital inpatient (>24 hour stay) in the last 14 days.	Prior-authorization #

Letter of Medical Necessity (LMN)

○ I have attached an LMN and/or other documents for insurance billing purposes.

○ I agree to allow Invitae to transfer the information from this requisition to an LMN and/or other documentation using the ordering physician's name as the signature for insurance billing.

○ INSTITUTIONAL BILLING

Invitae will send an invoice to the organization address above.
Please contact Invitae if this order should be billed to a different location.

○ PATIENT PAY BILLING

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

○ OTHER BILLING

Invitae partner code:

INVITAE

Patient's first name

Patient's last name

INVITAE CARRIER REQUISITION FORM

SPECIMEN INFORMATION

Label each tube with the patient's full name, date of birth, and specimen collection date. A requisition form MUST accompany each specimen. www.invitae.com/specimen-requirements

Collection date (MM/DD/YYYY)

If not provided, date will be 1 day prior to our receipt of specimen. For DNA, provide date retrieved from archive.

Specimen type

◯ Blood ◯ Saliva ◯ DNA - source: _____

DNA must be extracted in a CLIA or other suitably certified laboratory. We are unable to accept blood/saliva from patients with allogeneic bone marrow transplants or blood transfusion <2 weeks prior to specimen collection.

Special cases

◯ History of/current hematologic malignancy

◯ Resubmission

Specimen ID (IB# found on tube) - optional:

REPRODUCTIVE PARTNER INFORMATION (OPTIONAL)

Has Invitae carrier screening already been ordered for this individual's reproductive partner? ◯ No ◯ Yes

After carrier screening is ordered for a patient, their partner becomes eligible for $100 self-pay pricing. There is no need to wait for the first patient's result before ordering reduced-price testing for the partner - in this case, select 'yes' for only one of the patients.

Partner's requisition ID	Partner's first name	Partner's last name	Partner's date of birth

REASON FOR TESTING

Please select all reasons for testing that apply

◯ Screening (no family history)

◯ Patient/partner is pregnant
Estimated due date: _____

◯ Gamete donor

◯ Family history. Please specify disorder(s) and relationship(s):

◯ Patients's partner is a known carrier. Please specify disorder(s):

◯ Other reason. Please explain: _____

ICD-10 codes

◯	Z31.430	Female screening for carrier status for procreative management
◯	Z31.440	Male screening for carrier status for procreative management
◯	Z13.17	Nonprocreative screening for genetic disease carrier status
◯	Z34.90	Supervision of normal pregnancy
◯	O09.00	Supervision of pregnancy with history of infertility
◯	O35.2XX0	Maternal care for suspected hereditary disease in fetus
◯	Z15.89	Genetic susceptibility to disease/high-risk ethnicity
◯	Z84.81	Family history of carrier of genetic disease
◯	Z81.0	Family history of intellectual disabilities
◯	N97.9	Female infertility
◯	N46.9	Male infertility
◯	Other:	

TEST INFORMATION

COMPREHENSIVE CARRIER SCREENS	# gene(s)
◯ 60100 Invitae Comprehensive Carrier Screen	288
◯ 60100.1 Add-on genes with variable presentation	13
◯ 60200 Invitae Comprehensive Carrier Screen without X-Linked Disorders	267
◯ 60200.1 Add-on genes with variable presentation	12
BROAD CARRIER SCREENS	**# gene(s)**
◯ 60101 Invitae Broad Carrier Screen	46
◯ 60201 Invitae Broad Carrier Screen without X-Linked Disorders	41
CORE CARRIER SCREENS	**# gene(s)**
◯ 60102 Invitae Core Carrier Screen (CF, SMA, fragile X)	3
◯ 60102.1 Add-on alpha-thalassemia genes	2
◯ 60102.2 Add-on HBB-related hemoglobinopathies gene	1
◯ 60104 Invitae Core Carrier Screen without X-Linked Disorders (CF, SMA)	2
◯ 60104.1 Add-on alpha-thalassemia genes	2
◯ 60104.2 Add-on HBB-related hemoglobinopathies gene	1

CUSTOM PANEL ID

Invitae supports customization of your test. To create a custom panel, log in to your Invitae portal account or contact Client Services. Then indicate the ID associated with that panel here.

Custom panel ID

To request a complimentary specimen collection kit visit
www.invitae.com/request-a-kit

SHIPPING INSTRUCTIONS

Please ship specimen overnight in insulated containers:
Attn: Invitae Client Services,
1400 16th Street, San Francisco, CA 94103, USA

*Invitae continually updates its panels based on the most recent evidence. Please note that if an order is placed using an older version of these forms, Invitae reserves the right to upgrade any ordered panel(s) to the current version(s). To view a full gene list, visit our website at **www.invitae.com/carrier-screening**.*

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/carrier-consent), 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 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	Date