INVITAE

ORDER ID
For Invitae internal use only

INVITAE CARRIER SCREENING 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 (billing and report access after clinician releases)	Mobile phone (for billing contact)	Ancestry: ◯ Asian ◯ Black/African American ◯ White/Caucasian ◯ Ashkenazi Jewish ◯ Hispanic ◯ Native American ◯ Pacific Islander ◯ French Canadian ◯ Sephardic Jewish ◯ Other: _____

Address	City	State/Prov	Zip/Postal code	Country

Ship a saliva kit to this patient (to submit this request, fax this completed requisition form to Invitae Client Services at 415-276-4164)
◯ Ship kit to address above ◯ Ship kit to alternate address: _____

INSURANCE INFORMATION (Provide only if applicable. Attach front and back of insurance card, clinical notes and medical records. Insurance is not accepted for patients outside the US.)

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

Patient relationship to policyholder ◯ Self ◯ Spouse ◯ Child ◯ Other: _____	Secondary insurance company name	Secondary member ID #	Secondary insurance phone	Prior-authorization #

CLINICIAN INFORMATION

Organization name	Phone	Fax

Address	City	State/Prov	Zip/Postal code	Country

Primary clinical contact name (if different from ordering provider)	NPI	Email address (for report access)

Ordering provider (Pre-populate your provider list below. For each order, indicate **one** ordering provider by marking the checkbox before the name)

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

Additional clinical or laboratory contacts (optional) ◯ Share this order with the primary clinical contact's default clinical team (manage team online at www.invitae.com/signin)

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

CARRIER SCREENING

INVITAE PANELS

◯ 60100 Invitae Comprehensive Carrier Screen (288 genes)
- ◯ 60100.1 Add-on genes with variable presentation (13 genes)

◯ 60200 Invitae Comprehensive Carrier Screen without X-Linked Disorders (267 genes)
- ◯ 60200.1 Add-on genes with variable presentation (12 genes)

◯ 60101 Invitae Broad Carrier Screen (46 genes)

◯ 60201 Invitae Broad Carrier Screen without X-Linked Disorders (41 genes)

◯ 60102 Invitae Core Carrier Screen - CF, SMA, fragile X (3 genes)
- ◯ 60102.1 Add-on alpha-thalassemia genes (2 genes)
- ◯ 60102.1 Add-on HBB-related hemoglobinopathies gene (1 gene)

◯ 60104 Invitae Core Carrier Screen without X-Linked Disorders - CF, SMA (2 genes)
- ◯ 60104.1 Add-on alpha-thalassemia genes (2 genes)
- ◯ 60104.2 Add-on HBB-related hemoglobinopathies gene (1 gene)

CUSTOM PANEL ID

◯ _____ *Provide eight character ID. To create a custom panel ID, log in to your Invitae portal or contact Client Services*

Specimen type: Blood (6-mL purple EDTA tube) -OR- Saliva (Oragene™ kit)

Carrier collection date (MM/DD/YYYY): *If not provided, the day before specimen receipt will be used* ____ / ____ / ____

Reason for testing (select all that apply):
◯ Screening (no family history) ◯ Gamete donor ◯ Other: _____
◯ Family history. Specify disorder(s) and relationship: _____
◯ Patient's partner is a known carrier. Specify disorder(s): _____
◯ Patient/partner is pregnant. Estimated due date (MM/DD/YYYY): ____ / ____ / ____

Has Invitae carrier screening already been ordered for this individual's reproductive partner?
After the initial test is ordered, the patient's partner is eligible for $100 patient pay pricing ***(select 'yes' for only one patient)***
◯ No ◯ Yes: Partner name/Invitae RQ: _____ DOB: ____ / ____ / ____

Billing selection (select one):
◯ Patient pay
◯ Institutional
◯ Insurance (**ICD-10 code(s) below required**):
- ◯ Z31.430 Female carrier screening
- ◯ Z31.440 Male carrier screening
- ◯ Z34.90 Supervision of normal pregnancy
- ◯ Z84.81 Family history of carrier status
- ◯ Z15.89 Genetic susceptibility to disease
- ◯ Other ICD-10: _____

If an order is placed using an outdated test requisition form, Invitae reserves the right to upgrade ordered tests to the current versions. View current requisition forms at ***www.invitae.com/forms****.*
Please note: *Test IDs containing add-on codes will include the original panel as well as the add-on.*

Healthcare providers can order specimen collection kits online at
www.invitae.com/request-a-kit.

SHIPPING INSTRUCTIONS
Please ship specimen to Invitae:
Attn: Invitae Client Services
1400 16th Street
San Francisco, CA 94103 USA

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/forms). For orders originating outside the US, the Patient has been informed their personal information and specimen will be transferred to and processed in the US. The Patient has been informed that Invitae may notify them of clinical updates related to genetic test results (in consultation with the ordering medical professional). If insurance billing is selected, the Patient has further been informed and authorizes Invitae Corporation ("Invitae") and its designees to release information concerning testing to their insurer in order to process and/or appeal claims. The medical professional agrees to allow Invitae to transfer the information from this requisition to a letter of medical necessity and/or other documentation using the medical professional's name as the signature. 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. I attest that I am authorized under applicable law to order this test.

Medical professional signature (required)	**Date (MM/DD/YYYY)**