Requisition Form – Pregnancy Loss

Miscarriage, Recurrent Pregnancy Loss, Intrauterine Fetal Demise, Stillbirth

Client Information

Referring Physician ______________ NPI ______________

Ordering Physician ______________ NPI ______________

Genetic Counselor/Clinical Contact ______________

Tel ______________ Fax ______________

Email ______________

Authorized Signature ______________

Billing Information

Bill: ❑ My Account ❑ Insurance ❑ Medicare ❑ Medicaid ❑ Patient

Insurance Information ❑ See attached

Insured Information Name ______________

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other: ______________

Primary Insurance Company ______________ Authorization # ______________

Group # ______________ Subscriber ID # ______________

Billing Address ______________

Billing City, State, Zip ______________

Secondary Insurance Company ______________ Authorization # ______________

Group # ______________ Subscriber ID # ______________

Billing Address ______________

Billing City, State, Zip ______________

For Patient Bill cases, complete and submit "Self-Pay Testing Option" form. Testing will not be performed unless a completed form is received.

Patient Authorization/Assignment

I authorize CombiMatrix to obtain and release relevant medical and other information as needed to submit claims to Medicaid, Medicare, or Medicare Supplemental for laboratory services CombiMatrix provides to me. I assign insurance benefits to CombiMatrix and acknowledge that charges not covered by my insurance, including any applicable co-payments or deductibles, are my responsibility, and I agree to pay them.

____
Print Name of Patient

Signature of Patient Date (mm/dd/yyyy)

Patient Information

Last Name ______________ First Name ______________

DOB ______________ Gender ______________

Street Address ______________

City, State Zip ______________

Tel ______________

Email ______________

Medical Record Number ______________

Pregnancy History

Gravida ________ Para ________ SABs ________ TABs ________

How many fetuses? ❑ 1 ❑ 2 ❑ 3

Gestational age: ________ Weeks ________ Days ❑ Unknown

Fetal gender: ❑ Female ❑ Male ❑ Unknown

Fetal karyotype: ❑ 46,XX ❑ 46,XY ❑ Not performed ❑ Pending ❑ Abnormal*

NIPT results: ❑ Not performed ❑ Normal ❑ Abnormal*

**** If fetal karyotype or NIPT results were ABNORMAL, please enclose a copy of the report****

Miscarriage Analysis Indications

❑ Recurrent Pregnancy Loss (N96)

❑ Intrauterine Fetal Demise >20 weeks (O36.4XX1)

❑ Miscarriage/Spontaneous Abortion (O03.9)

❑ Therapeutic Abortion (Z33.2)

❑ Missed Abortion (O02.1)

❑ Stillbirth (Z37.1)

❑ Other ______________ ICD-10 ______________

Miscarriage Analysis Testing

❑ CombiSNP™ Microarray

Sample Type

❑ Fresh tissue ❑ FFPE block ❑ FFPE slides

❑ Chorionic villi ❑ Cultured CVS ❑ Cultured amniocytes ❑ Amniotic fluid

❑ Cultured fetal cells ❑ DNA (Source: ______________)

Collection Date ______________ # Tubes/ blocks ______________

Specimen ID #(s) ______________

Special Instructions/Additional Testing Requests

Please be sure to include as much information as possible regarding any fetal anomalies, as it improves the quality of the interpretation of the microarray results.

© CombiMatrix. All rights reserved. ASR-F-090-1222017