INVITAE

ORDER ID
For Invitae internal use only

INVITAE NIPS 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	

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)

NON-INVASIVE PRENATAL SCREENING (NIPS)

SINGLETON PREGNANCIES

◯ 71001 Invitae NIPS for singleton pregnancies (chromosomes 13, 18, 21)
- ◯ 71001.1 Add-on for sex chromosomes (will report predicted fetal sex)
- ◯ 71001.2 Add-on for microdeletions (1p36, 4p16.3, 5p15.2, 15q11.2, 22q11.2)

TWIN PREGNANCIES

◯ 71002 Invitae NIPS for twin pregnancies (chromosomes 13, 18, 21)
- ◯ 71002.1 Add-on for presence of Y chromosome (to infer predicted fetal sex)

Specimen Type: Blood (10-mL black and tan Streck Cell-Free DNA tubes, 2 tubes)

NIPS collection date (MM/DD/YYYY): ____ / ____ / ____

Patient's estimated due date: ____ / ____ / ____
Required: minimum 10 weeks gestational age

Reason for testing (select all that apply):

◯ Advanced maternal age (>35 years) ◯ Average risk pregnancy ◯ Other: _____
◯ Positive serum screen: _____
◯ Abnormal ultrasound: _____
◯ History suggestive of increased risk: _____

Billing selection (select one):

◯ Patient pay
◯ Institutional
◯ Insurance (**ICD-10 code(s) below required**):

AMA: Primigravida ◯ O09.511 1st trimester (tri) ◯ O09.512 2nd tri ◯ O09.513 3rd tri
AMA: Multigravida ◯ O09.521 1st trimester (tri) ◯ O09.522 2nd tri ◯ O09.523 3rd tri
◯ Z34.90 Supervision of normal pregnancy ◯ O28.3 Abnormal ultrasonic finding
◯ O28.9 Abnormal finding, unspecified ◯ Other ICD-10: _____

Invitae NIPS is a laboratory-developed test that was validated under Federal CLIA laboratory guidelines by Verinata Health, Inc, a wholly owned subsidiary of Illumina, Inc. and available through contract with Invitae Incorporation.

If an order is placed using an older version of this 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.*

To request a complimentary specimen collection kit, visit
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. 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**