PRENATAL REQUISITION

Center for Human Genetics, Inc.
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FOR **CHG** LAB USE ONLY:
Date received: ______
Time: ______
Pedigree #: ______
Family name: ______
Sample type: ______
Lab #: ______

Patient Name: ______ (Last, First, MI)

Date of Birth: ______

Address: ______
______ (City, State, Zip Code)

SSN: ______
Phone: ______

Referring Provider: NPI:(10 digits required) ______
Name: ______
Address: ______
______ (City, State, Zip Code)
Phone: ______ Fax: ______

Referring Laboratory (if different):
Name: ______
Address: ______
______ (City, State, Zip Code)
Phone: ______ Fax: ______

MATERNAL SERUM SCREENING:

Test ordered:
- □ First trimester screen (10w4d-13w6d); PAPP-A, hCG
- □ Second trimester (quad) screen (15w0d-22w6d); AFP, hCG, uE3, Inhibin A
- □ Maternal serum AFP only (15w0d-22w6d)

Date of collection: ______

Clinical information:
Insulin dependent diabetes? □ Yes □ No
Weight: ______
Ethnicity: □ Caucasian □ Black □ Chinese □ Other Asian □ Other (specify): ______
Smoker? □ Yes □ No
□ Singleton □ Twins □ Other (specify): ______

LMP date: ______
Ultrasound date: ______
Gestational age at ultrasound: ______
NT: ______mm
NT: ______mm (twin, if applicable)
Sonographer name/NTQR ID#: ______

PRENATAL DIAGNOSIS:

Sample type: □ Amniotic fluid □ CVS □ Fetal blood □ Other (specify): ______

Date of collection: ______

Test ordered:
- □ Rapid FISH (interphase) analysis [13, 18, 21, X, Y]
- □ Chromosomes (includes AF-AFP analysis)
- □ Acetylcholinesterase and fetal hemoglobin
- □ FISH22
- □ DNA (specify): ______
  (call before sending samples)

Indication for study:
- □ Maternal age
- □ Abnormal ultrasound**
- □ Abnormal seum screen**
- □ Family genetic disorder**
- □ Other**

Clinical information:
LMP date: ______
Ultrasound date: ______
Gestational age at ultrasound: ______

** Please provide additional information:
______
______
______

Ethnicity: □ Caucasian □ African American □ Hispanic □ Asian □ Mediterranean □ Ashkenazi/Sephardic Jewish □ French Canadian □ Other: ______

FOR **CHG** LAB USE ONLY:
Report date: ______
Result: ______
Contact: ______
Reported by: ______

BILLING INFORMATION AND COPY OF INSURANCE CARD FRONT AND BACK MUST ACCOMPANY SAMPLE AND REQUISITION FORM

SVC PROVIDER: CENTER FOR HUMAN GENETICS INC@BUSM CLIA #22D0650242 NPI #1821153156

PATIENT INFORMATION:

LAST NAME: FIRST NAME: MIDDLE:	GENDER: (CIRCLE) M F	DATE OF BIRTH / / MM/DD/YYYY
STREET ADDRESS:		APARTMENT# / FLOOR
CITY :	STATE	ZIP
PHONE: HOME( )	CELL( )	

PAYMENT INFO: (SELECT ONE) (CIRCLE): LAB/HOSP/FAC/INST INSURANCE PATIENT CREDIT CARD

BILLING INFORMATION (MUST BE COMPLETED)

LABORATORY/ HOSPITAL/ FACILITY/ INSTITUTIONAL BILLING ADDRESS:

FACILITY NAME:
ADDRESS:
CITY, STATE, ZIP
ATTENTION:
PHONE: ( )
FAX: ( )
PURCHASE ORDER#
PATIENT MEDICAL RECORD#

AFFIX LABEL HERE:

INSURANCE INFORMATION:

INSURANCE COMPANY NAME:
INSURANCE IDENTIFICATION #
INSURANCE GROUP #

SUBSCRIBER NAME: LAST: FIRST:	SUBSCRIBER DATE OF BIRTH: / / MM / DD / YYYY
RELATIONSHIP TO PATIENT:	(CIRCLE): SELF PARENT SPOUSE
INSURANCE ADDRESS: STREET:	INSURANCE TELEPHONE AND EXTENTION: ( ) FAX# ( ) CONTACT NAME/DEPT:
CITY, STATE, ZIP:	AUTHORIZATION# VALID FROM: / / TO / /

*SECONDARY INS NAME:
RELATIONSHIP:
POLICY #
GENDER: M F

SUB NAME:
SUB DOB: / /

PATIENT ACKNOWLEDGEMENT:
I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO ANY INSURANCE CARRIER ANY INFORMATION NEEDED FOR THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST THAT THE PAYMENT OF MEDICAL INSURANCE BE PAID TO CHG, INC. I ALSO UNDERSTAND THAT I WILL BE HELD RESPONSIBLE FOR ANY PORTION OF THE CLAIM THAT THE INSURANCE COMPANY DOES NOT PAY.

REQUIRED SIGNATURE:
DATE: / /

MEDICARE ID#: BENEFICIARY NAME:

BENEFICIARY AGREEMENT:
I HAVE BEEN NOTIFIED BY THE CENTER FOR HUMAN GENETICS THAT, IN MY CASE, MEDICARE IS LIKELY TO DENY PAYMENT FOR THE SERVICES IDENTIFIED BELOW, FOR THE REASON STATED. IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT.

REQUIRED BENEFICIARY SIGNATURE:
DATE: / /

MEDICARE WILL ONLY PAY FOR SERVICES THAT IT DETERMINES TO BE “REASONABLE AND NECESSARY” UNDER SECTION 1862(a) (1) OF THE MEDICARE LAW.
IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH IT WOULD OTHERWISE BE COVERED, IS NOT “REASONABLE AND NECESSARY” UNDER MEDICARE PAYMENT STANDARDS, MEDICARE WILL DENY PAYMENT FOR THAT SERVICE. THE CENTER FOR HUMAN GENETICS BELIEVES THAT MEDICARE IS LIKELY TO DENY PAYMENT FOR MOLECULAR DNA TESTING. PROVIDER #228243