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Clinical Questionnaire for Reveal® SNP Microarray - Prenatal & POC

Prior authorization questions, call **866-248-1265.** / Fax **855-711-5699** / Test questions, call **800-345-4363.**

Name and title of person completing this form _____

Test Information (this is not an order for a test)

Note: For Medicare recipients, a signed ABN must accompany the sample if an ICD-10 Code that supports medical necessity is not provided.						
ICD-10 Diagnosis Code(s) **Required**						

Test No.	Test Name

Specimen Type: ◯ Amniotic fluid ◯ Chorionic villi ◯ POC ◯ Prenatal fetal blood ◯ Postnatal cord blood

Patient Demographics

Patient's name _____ / Date of birth_____ / Sex: ◯ Male ◯ Female

Patient/guardian phone no. _____ / Patient/guardian email _____

Patient History

Select at least one: ◯ Genetic counseling performed by board-certified genetic counselor or clinical geneticist. If marked, attach genetic counseling report.
◯ Pretest counseling performed by ordering provider or designee in accordance with health plan policies. Post-test counseling will be available.

Fetal Sex: ◯ Male ◯ Female ◯ Unknown / **Method** (eg, ultrasound, CfDNA, chromosomes, PGT, FISH):_____

Primary indication:_____ Gestational age: _____

G___P___ ___ ___ ___ Is this a twin/multiples pregnancy? ◯ **Yes** ◯ **No** If yes, check one: ◯ MZ ◯ DZ ◯ Unknown

Was pregnancy achieved through ART? If so, how: ◯ **Egg donor** ◯ **Sperm donor** ◯ **Self-donor** ◯ **Other donor** ◯ **IVF** ◯ **ICSI**

Was preimplantation genetic testing (PGT) performed? ◯ **Yes** ◯ **No**

Abnormal maternal serum screening: ◯ Yes ◯ No If yes, indicate results:_____

Abnormal CfDNA results: ◯ Yes ◯ No If yes, attach results.

Abnormal ultrasound: ◯ Yes ◯ No If yes, provide details: _____

Previous Genetic Test Results (if known—karyotype, microarray, sequencing, exome, etc)

Current pregnancy: _____ Date performed:_____ Lab: _____

Previous pregnancy:_____ Date performed:_____ Lab: _____

Parental chromosomes: Maternal _____ Date performed:_____ Lab: _____

Paternal _____ Date performed:_____ Lab: _____

Significant Family History

◯ Unknown or limited family history? Please explain (eg, adopted) _____

Relative*	**Maternal / Paternal**	**Condition/Clinical Diagnosis/Previous Genetic Test Results**	**Has genetic testing been performed?** If yes, attach lab report.
	☐ / ☐		☐ Yes ☐ No
	☐ / ☐		☐ Yes ☐ No
	☐ / ☐		☐ Yes ☐ No

Genetic Counseling—Ordering provider understands by signing below:
If genetic counseling by a board-certified genetic counselor is required by the health plan prior to laboratory testing but has not occurred as indicated in the Patient History section above, I understand that a referral may be made by the laboratory to a board-certified genetic counselor required or authorized by the health plan.
Such referral is solely related to laboratory testing and does not relieve me of any obligation to seek authorization for my services.

Account No.: _____

Provider Name (print): _____ NPI: _____

Provider Phone No.: _____ Fax No.: _____

_____ / _____
Ordering Provider Signature **Date**

Patient understands by signing below:
Labcorp may use information obtained on this form and other information provided by me and/or my ordering provider or his/her designee to initiate prior authorization with my health plan as required. I understand a prior authorization approval from my health plan does not guarantee full payment. It is my responsibility to contact my health plan regarding concerns over my coverage and benefits.

_____
Patient Signature

_____
Date

*Relationships to consider include parents, siblings, offspring (1st degree), half-brothers/sisters, aunts/uncles, grandparents, grandchildren, nieces/nephews (2nd degree); first cousins, great-aunts/uncles, great-grandchildren, great grandparents (3rd degree).

TIN: 13-3757370 / NPI: 1750368700

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