

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.