

Client Information

Referring Physician _____ NPI _____
 Genetic Counselor/Clinical Contact _____
 Tel _____ Fax _____
 Email _____
 Authorized Signature _____

Patient Information

Last Name _____ First Name _____
 DOB _____ Gender _____
 Street Address _____
 City, State Zip _____
 Tel _____
 Email _____
 Medical Record Number _____

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 # _____ Insured # _____

Billing Address _____

Billing City, State, Zip _____

Secondary Insurance Company _____ Authorization # _____

Group # _____ Insured # _____

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 or Guardian

 Signature of Patient or Guardian

 Date (mm/dd/yyyy)

Specimen Information

Collection Date _____ # Tubes _____

Specimen ID #(s) _____

Sample Type

Whole blood - EDTA (purple top) Whole blood - NaHep (green top)

Buccal swab (microarray only) Extracted DNA

Other _____

Indication for Testing

Parental/Familial Studies

If the patient or family member was previously tested at CombiMatrix, please complete this section.

Evaluation of genetic disease carrier status for procreative management

Female (Z31.430) Male (Z31.440)

Family history of a chromosome abnormality (Z82.79)

Other (description and ICD-10) _____

Previously Tested Individual's Information

Name (Last, First, MI) _____ DOB _____

CombiMatrix Accession# _____ Year of Testing _____

Relationship to Patient _____

Recurrent Pregnancy Loss Studies (Karyotyping)

Female recurrent pregnancy loss (N96)

Male partner of patient with recurrent pregnancy loss (Z31.441)

Maternal Cell Contamination (MCC) Studies

If you are sending maternal blood for MCC analysis, please utilize the same ICD-10 code(s) as indicated on the original order.

Indication for prenatal diagnostic testing (ICD-10) _____

Test Selections

Parental/Familial Studies

If a family member has had an abnormal result or a variant of unclear significance (VOUS) identified and parental/familial studies are recommended, the report will indicate which type of testing is to be performed. If you are uncertain regarding the recommended test type, please contact our Genetic Counseling Team at 949.753.0624 option 3.

Chromosomal microarray analysis (purple top/EDTA or buccal swab)

FISH (green top/NaHep)

Karyotype (green top/NaHep)

Recurrent Pregnancy Loss

Karyotype (green top/NaHep)

Maternal Cell Contamination (MCC) Studies (purple top/EDTA)

MCC analysis following testing of a prenatal sample

MCC analysis to accompany cultured prenatal sample for send-out testing

Special Instructions/Additional Testing Requests