REQUESTED BY

1A

1B

1C

LabCorp

INHERITEST® 500 PLUS WITH REPRO PARTNERS REPORT

Send additional copy of report to:

☐ Fax

☐ Call _____ (Client Number/Physician's Name) (___) _____ (Phone/Fax Number)

0550.02

To find the nearest patient service center, visit www.labcorp.com or call 888-LABCORP (888-522-2677).

Patient's Legal Name (Last, First, MI)	Sex	Date of Birth MO DAY YR	Collection Time : AM PM	Fasting ☐ Yes ☐ No	Collection Date MO DAY YR	Urine hrs/vol hrs _____ vol _____

NPI	Physician's ID #	Patient's ID #	Hospital Patient Status: ☐ In-Patient ☐ Out-Patient ☐ Non-Patient

Physician's Name (Last, First) _____ Physician/Authorized Signature X _____

Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service

Highest Specificity REQUIRED

PATIENT

Patient's Address _____ Phone _____

City _____ State _____ ZIP _____

RESP. PARTY

Name of Policy Holder (if different from patient) _____

Address of Policy Holder _____ APT # _____

City _____ State _____ ZIP _____

PRIMARY BILLING PARTY	SECONDARY BILLING PARTY
Insurance Carrier *	Insurance Carrier *
ID #	ID #
Group #	Group #
Insurance Address	Insurance Address
Name of Insured Person	Name of Insured Person
Relationship to Patient	Relationship to Patient
Employer Name	Employer Name
*If Medicaid State / Physician's Provider # / Workers Comp ☐ Yes ☐ No	

I hereby authorize the release of medical information related to the service described herein and authorize payment directly to LabCorp. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.

X _____ (Patient's Signature) _____ (Date)

MEDICARE ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

Refer to policies published by your Medicare Administrative Contractor (MAC), CMS, or www.LabCorp.com/MedicareMedicalNecessity when ordering tests that are subject to ABN guidelines.

INFORMED CONSENT

I have obtained informed consent for the above ordered genetic test(s). (Required)

_____ Physician's Signature

PLEASE PRINT

PLEASE PRINT

Specimen type ❑ Peripheral blood Pregnant ❑ YES ❑ NO

Ethnicities (check all that apply): ❑ Caucasian ❑ Ashkenazi Jewish ❑ Sephardic Jewish ❑ Asian ❑ African American ❑ Native American ❑ Hispanic

❑ Other: _____

Indication for testing (if not checked, screening assumed)

❑ No family history ❑ abnormal fetal u/s* ❑ family history: relative* ❑ known carrier* ❑ infertility ❑ reproductive partner is known carrier*

* Provide additional information: _____

Inheritest® Carrier Screen (select one)

630049 ❑ Inheritest® 500 PLUS Panel**

630217 ❑ Inheritest® 500 PLUS with Repro** Partners Report

- Combined reproductive partner reporting is available when both partners have the same test on the same day ordered by the same provider
- A separate requisition must be completed for each partner and samples must be sent together
- Consent must be signed on both requisitions

**X-linked disorders are not tested in males

REPRODUCTIVE PARTNER INFORMATION (for Repro Partners Reports only)
Complete a separate requisition for each partner

Name _____ (Last) _____ (First) _____ (MI)

☐ Male ☐ Female Date of Birth / /

CONSENT FOR PARTNERS REPORTING
SIGNATURE REQUIRED FOR BOTH PATIENT AND REPRODUCTIVE PARTNER ON THEIR RESPECTIVE REQUISITIONS

If consent is not provided for both patient and reproductive partner, test will be changed to 630049 Inheritest® 500 PLUS Panel and a Repro Partners Report will not be generated.

For the purpose of obtaining risk information for a current or intended pregnancy with this reproductive partner only, I expressly consent that Integrated Genetics will create a report that includes both my and my reproductive partners test results. I understand that this requires that I share my protected health information, specifically these test results, with this reproductive partner. I understand that an individual report with only my result will not be generated.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____/_____/_____

ORIGINAL-LABORATORY / COPY-CLIENT

FORM # 0550

(REV 11/23/2020)

NOTE: WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDICAID REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT. COMPONENTS OF THE ORGAN OR DISEASE PANELS/COMBINATIONS PRINTED ABOVE ARE SHOWN ON THE REVERSE SIDE AND MAY ALSO BE ORDERED INDIVIDUALLY ABOVE. COMPONENTS MAY BE BILLED SEPARATELY PER CARRIER POLICY.