

1. PATIENT INFORMATION				MRN
Legal Name (Last)	Legal Name (First, MI)	Sex Assigned at Birth <input type="checkbox"/> F <input type="checkbox"/> M	Gender (optional) <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Nonbinary <input type="checkbox"/> Self-described _____	Date of Birth (MM/DD/YY)
Genetic Ancestry: <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> French Canadian/Cajun <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mediterranean <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Portuguese <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <small>See Carrier Screening Ethnicity section on page 2</small>		Address	City	State Zip
		Phone	Email	

2. PROVIDER INFORMATION			
Organization Name, Number	Address	City, State	Zip
Ordering Provider Name (Last, First), Ambry Number <input type="checkbox"/> _____ <input type="checkbox"/> _____	NPI <input type="checkbox"/> _____	Primary Contact(s) <input type="checkbox"/> _____	
<input type="checkbox"/> _____ <input type="checkbox"/> _____	Phone Number <input type="checkbox"/> _____	<input type="checkbox"/> _____	
<input type="checkbox"/> _____ <input type="checkbox"/> _____	Email/Fax <input type="checkbox"/> _____	<input type="checkbox"/> _____	

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING:
 According to clinical care recommendations for NIPT, informed decision-making should take place prior to the sample collection. Please refer to published standards for more information. The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent. I confirm that testing is medically necessary and that test results may impact medical management for the patient. I agree to allow Ambry Genetics to facilitate the provision of post-test genetic counseling services by a third-party service, as required by the patient's insurance provider. Furthermore, all information on this TRF is true to the best of my knowledge. My signature applies to the attached letter of medical necessity.

Medical Professional Signature (I agree to terms below):	Date:
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3. BILLING INFORMATION (SELECT ONE)		
<input checked="" type="checkbox"/> INSURANCE (Attach front and back of insurance card) Insurance Name _____ Group # _____ Member ID # _____ Member Name _____ Prior Authorization Number (If applicable, please attach) _____	<input type="checkbox"/> INSTITUTIONAL Facility Name _____ Contact Name _____ Address _____ Phone Number _____ Email/Fax _____	<input type="checkbox"/> PATIENT <input type="checkbox"/> Check to Ambry Genetics <input type="checkbox"/> Credit Card (Ambry will contact patient for payment)

TERMS AND CONDITIONS	
<p>Patient Acknowledgement: I acknowledge that the information provided by me is true and correct. For direct insurance billing: I authorize my insurance benefits to be paid directly to Ambry Genetics Corporation (Ambry), authorize Ambry to release medical information concerning my testing to my insurer, to be my designated representative for purposes of appealing any denial of benefits as needed and to request additional medical records for this purpose. I understand that I am financially responsible for any amounts not covered by my insurer and responsible for sending Ambry money received from my health insurance company.</p> <p><input type="checkbox"/> I agree to be contacted regarding future research studies for which I may be a candidate. Any future research projects will be subject to a separate informed consent process and participation is voluntary. Learn more about Ambry's privacy practices at https://www.ambrygen.com/legal/notice-of-privacy-practices.</p> <p>For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated above. In order to expedite consideration for eligibility for Ambry's Patient Assistance Program, please provide the total annual gross household income: \$ _____ and the number of family members in the household supported by the listed income: _____. I authorize Ambry Genetics Corporation to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.</p> <p><input type="checkbox"/> For NY Residents: By checking this box, I agree that Ambry Genetics may retain my sample for 6 months after the testing above has been completed. By not checking this box, I understand that under New York State law, Ambry Genetics must discard my sample after the longer of (a) testing completion and (b) 60 days after the Date of Collection above.</p>	
Patient Signature (I agree to terms above):	Date:

4. PREGNANCY INFORMATION & test selection	
<p>REQUIRED: Complete Section</p> <p>Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No First Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Preconception planning? <input type="checkbox"/> Yes <input type="checkbox"/> No Has pre-test counseling been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pregnancy type: <input type="checkbox"/> Singleton <input type="checkbox"/> Twin <input type="checkbox"/> Unknown Maternal BMI _____ Was the pre-test counseling performed by a board-certified or board-eligible genetic specialist? (i.e genetic counselor, nurse, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Estimated Delivery Date (EDD) (MM/DD/YYYY) _____ <input type="checkbox"/> US <input type="checkbox"/> LMP ¹ Screening cannot be performed for higher order multiples</p> <p>Pregnancy conceived by reproductive technology? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was an egg donor used? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, age of egg donor _____</p>	

NIPT (NON-INVASIVE PRENATAL SCREENING)	CARRIER SCREENING
Use: (One) Blood 10mL STRECK Tiger Top (cfDNA) REQUIRED: Select Core Test <input type="checkbox"/> Chromosomes 21, 18, 13 (9080, 9081) Add-On Test <input type="checkbox"/> Sex Chromosomes ² (includes fetal sex) <input type="checkbox"/> All Chromosomes ³ (singleton only; includes fetal sex) <input type="checkbox"/> Microdeletions ³ (singleton only)	Use: (One) Blood 4mL EDTA Purple Top or Saliva (OG-500) REQUIRED: Select Core Test <input type="checkbox"/> CF + SMA (SMNI) (9082) <input type="checkbox"/> Ashkenazi Jewish (9083) (includes CF + SMA) Add-On Test <input type="checkbox"/> Guidelines-Based ⁴ (9085-A) <input type="checkbox"/> Comprehensive ⁴ (9086-A) <input type="checkbox"/> Fragile X ^{4,5} (9084-A)
Collection Date (Required) _____ <small>(Minimum 10 weeks gestational age)</small> Collection date is required for testing to proceed. Failure to provide may result in delays and/or test cancellation.	Collection Date (Required) _____ Collection date is required for testing to proceed. Failure to provide may result in delays and/or test cancellation.
Phlebotomy: <input type="checkbox"/> Yes, service required Clinical Indications Required. See supplementary ICD-10 guide on page 2. <input type="checkbox"/> ICD-10 Codes: _____ Relevant Ultrasound Findings: _____ Relevant Family History: _____	Phlebotomy: <input type="checkbox"/> Yes, service required Saliva Kit: <input type="checkbox"/> Send kit to patient Clinical Indications Required. See supplementary ICD-10 guide on page 2. <input type="checkbox"/> ICD-10 Codes: _____ Partner testing done at Ambry?: <input type="checkbox"/> Yes <input type="checkbox"/> No Ambry ID _____ Partner Name (First, Last) _____ DOB (mm/dd/yyyy) _____
² Twin sex chromosome analysis consists only of presence or absence of Y chromosome. ³ Microdeletion and all chromosome analysis are not available for twin gestations.	By providing the partner's information, I certify that I am the ordering provider / practice member for both partners. I have obtained each partner's consent to share their results and both parties will have access to each other's test results. ⁴ Males are not tested for X-linked disorders ⁵ Automatic reflex to AGG analysis in carrier patients who have a premutation with 55-90 CGG repeats

Sample Requirements & Related ICD-10 Codes

NIPT

Sample	Test Options
One 10mL Streck tiger top cell-Free DNA BCT® blood tube	Chromosomes 21, 18, 13
Note: Patients must be at least 10 weeks gestation.	<ul style="list-style-type: none"> • Sex Chromosomes² (includes fetal sex) • All Chromosomes³ (singleton only, includes fetal sex) • Microdeletions (singleton only)

² Twin sex chromosome analysis consists only of presence or absence of Y chromosome.

³ Microdeletions and All Chromosomes are not available for twin pregnancies

Review test specifications at

<https://www.ambrygen.com/providers/specimen-requirements>

General Screening

Encounter for other genetic testing of female for procreative management.....	Z31.438
Encounter for supervision of normal first pregnancy, unspecified trimester.....	Z34.00
Encounter for supervision of normal first pregnancy, 1st trimester.....	Z34.01
Encounter for supervision of normal first pregnancy, 2nd trimester.....	Z34.02
Encounter for supervision of normal first pregnancy, 3rd trimester.....	Z34.03
Encounter for supervision of other normal pregnancy, unspecified trimester.....	Z34.80
Encounter for supervision of other normal pregnancy, 1st trimester.....	Z34.81
Encounter for supervision of other normal pregnancy, 2nd trimester.....	Z34.82
Encounter for supervision of other normal pregnancy, 3rd trimester.....	Z34.83

Increased Risk

Supervision of elderly primigravida, 1st trimester.....	O09.511
Supervision of elderly primigravida, 2nd trimester.....	O09.512
Supervision of elderly primigravida, 3rd trimester.....	O09.513
Supervision of elderly primigravida, unspecified trimester.....	O09.519
Supervision of elderly multigravida, 1st trimester.....	O09.521
Supervision of elderly multigravida, 2nd trimester.....	O09.522
Supervision of elderly multigravida, 3rd trimester.....	O09.523

Supervision of elderly multigravida, unspecified trimester.....	O09.529
Supervision of other high risk pregnancies, 1st trimester.....	O09.891
Supervision of other high risk pregnancies, 2nd trimester.....	O09.892
Supervision of other high risk pregnancies, 3rd trimester.....	O09.893
Supervision of other high risk pregnancies, unspecified trimester.....	O09.899
Pregnancy care for patient with recurrent pregnancy loss, unspecified trimester.....	O26.20
Pregnancy care for patient with recurrent pregnancy loss, 1st trimester.....	O26.21
Pregnancy care for patient with recurrent pregnancy loss, 2nd trimester.....	O26.22
Pregnancy care for patient with recurrent pregnancy loss, 3rd trimester.....	O26.23

Abnormal Findings

Abnormal hematological finding on antenatal screening of mother.....	O28.0
Abnormal biochemical finding on antenatal screening of mother.....	O28.1
Abnormal radiological finding on antenatal screening of mother.....	O28.4
Abnormal chromosomal and genetic finding on antenatal screening of mother.....	O28.8
Abnormal chromosomal and genetic finding on antenatal screening of mother.....	O28.5
Other abnormal findings on antenatal screening of mother.....	O28.8
Unspecified abnormal findings on antenatal screening of mother.....	O28.9
Abnormal ultrasonic finding on antenatal screening of mother.....	O28.3
Abnormal chromosomal and genetic finding on antenatal screening of mother.....	O28.5
Maternal care for (suspected) chromosomal abnormality in fetus, unspecified.....	O35.1XX0
Maternal care for (suspected) chromosomal abnormality in fetus, unspecified.....	O35.1XX0
Encounter for antenatal screening for chromosomal anomalies.....	Z36.0
Maternal care for (suspected) hereditary disease in fetus, unspecified.....	O35.2XX0
Encounter for antenatal screening for raised alphafetoprotein level.....	Z36.1
Encounter for other antenatal screening follow-up.....	Z36.2
Encounter for other antenatal screening for malformations.....	Z36.3
Encounter for antenatal screening for fetal growth retardation.....	Z36.4
Encounter for antenatal screening for hydrops fetalis.....	Z36.81
Encounter for antenatal screening for nuchal translucency.....	Z36.82
Encounter for fetal screening for congenital cardiac abnormalities.....	Z36.83

Carrier Screening

Sample	Panels & Genes
One 4mL purple top EDTA tube -OR- One 2mL Oragene® saliva tube	CF+SMA (Cystic Fibrosis+Spinal Muscular Atrophy): 2 genes Ashkenazi Jewish: 48 genes Guidelines-Based: 163 genes Comprehensive: 418 genes Fragile X: 1 gene

Review test specifications at

<https://www.ambrygen.com/providers/specimen-requirements>

General Screening

Encounter for nonproductive screening for genetic disease carrier status.....	Z13.71
Encounter for screening for other specified diseases and disorders.....	Z13.8
Screening for other disorder.....	Z13.8
Cystic fibrosis carrier.....	Z14.1
Genetic carrier of other disease.....	Z14.8
Encounter for female for testing for genetic disease carrier status.....	Z31.430
Encounter for male for testing for genetic disease carrier status.....	Z31.440

Encounter for procreative genetic counseling.....	Z31.5
Encounter for supervision of normal first pregnancy, unspecified trimester.....	Z34.00
Encounter for supervision of normal first pregnancy, 1st trimester.....	Z34.01
Encounter for supervision of normal first pregnancy, 2nd trimester.....	Z34.02
Encounter for supervision of normal first pregnancy, 3rd trimester.....	Z34.03
Encounter for supervision of other normal pregnancy, unspecified trimester.....	Z34.80
Encounter for supervision of other normal pregnancy, 1st trimester.....	Z34.81
Encounter for supervision of other normal pregnancy, 2nd trimester.....	Z34.82
Encounter for supervision of other normal pregnancy, 3rd trimester.....	Z34.83
Encounter for antenatal screening for chromosomal anomalies.....	Z36.0
Encounter for antenatal screening for other genetic defects.....	Z36.8A
Encounter for genetic counseling.....	Z31.5

Family History

Family history of intellectual disabilities.....	Z81.0
Family history of other diseases of the musculoskeletal system and connective tissue.....	Z82.69
Family history of other congenital malformations, deformations and chromosomal abnormalities.....	Z82.79
Family history of carrier of genetic disease.....	Z84.81
Family history of other specified conditions.....	Z84.89

Carrier Screening Ethnicity

The following ethnicities can be written into the "Other" box on the front of this form under Patient Information. Specific patient ancestry may help with results for Carrier Screening.

Note: Insurance reimbursement for Ashkenazi Jewish panels is typically dependent on stated AJ ethnicity.

- East Asian (China, Japan, Korea)
- Finnish
- French Canadian
- Mennonite
- Northern European (Scandinavian, UK, Germany)
- Sephardic Jewish
- South Asian (India, Pakistan)
- Southeast Asian (Vietnam, Cambodia, Thailand)
- Southern European (Spain, Italy, Greece)