PerkinElmer *For the Better* | PerkinElmer GENOMICS

VANADIS® NIPT Requisition Form (page 1 of 3)

Please complete every field clearly. Missing information may result in a delay of sample processing.

PATIENT INFORMATION

First Name | Date of Birth (MM/DD/YY)

Last Name | Patient ID Number

Patient's Street Address

City / Town | State | Postal Code

Country | Patient's Preferred Phone

Patient's Email (Used for communication of insurance coverage and billing information)

ORDERING ACCOUNT

Provider's First and Last Name

PerkinElmer Account Number | NPI

Clinic/Hospital/Laboratory Name

Primary Contact Email | Primary Contact Phone

Account Street Address

City / Town | State | Postal Code

Country | Account Fax

PREGNANCY DETAILS

Estimated Date of Delivery: MM/DD/YY Dating by: ☐LMP ☐Ultrasound

Maternal Weight: _____ ☐lbs ☐kg Maternal Height: _____ ☐ft/in ☐cm

Fetus Details

☐Singleton ☐Twins If Twins: ☐Monochorionic ☐Dichorionic

Conception Details

Conception Method (select all that apply): ☐Spontaneous/Natural ☐IVF ☐ICSI ☐PGS/PGT-A ☐Ovulation drugs ☐Other assisted reproduction

If IVF pregnancy, egg source: ☐Self ☐Donor

Age of donor/self at time of extraction:_____

Maternal History

	Yes	No
Insulin Dependent Diabetes Mellitus (IDDM)	☐	☐
Diabetes Type II	☐	☐
If yes, is she using insulin?	☐	☐
Smoking	☐	☐
Is this patient's first pregnancy?	☐	☐

If no, number of pregnancies after 24 weeks:_____

ETHNICITY (check all that apply):

☐African American
Asian
- ☐Indian subcontinent
- ☐Chinese
- ☐Filipino
- ☐Japanese
- ☐Korean
- ☐Other Asian descent

☐Caucasian - Non Hispanic
☐French Canadian
☐Hispanic
☐Jewish - Ashkenazi
☐Mediterranean
☐Middle Eastern
☐Native American
☐Pacific Islander
☐Other (specify):_____

PATIENT SAMPLE AND CLINICAL INDICATION

Collection Date: MM/DD/YY Was this sample collected in NY State: ☐Yes ☐No

ICD-10 code(s) required:

☐Screening for genetic and chromosomal anomalies – Z13.79
☐Supervision of normal pregnancy - Z34.90

AMA Primigravida: ☐1st trimester - 009.511 ☐2nd trimester - 009.512
AMA Multigravida: ☐1st trimester - 009.521 ☐2nd trimester - 009.522

☐Abnormal ultrasonic finding - 028.3
☐Abnormal serum screening - 028.1
☐Abnormal finding unspecified - 028.9
☐History of recurrent pregnancy loss - 026.20
☐Maternal care for (suspected) chromosomal abnormality in fetus - 035.1XX0
☐Other ICD-10: _____

TEST MENU (select one)

NIPT Screening Options:

Vanadis® NIPT (Trisomies 21, 18, 13 only)
- ☐VAN110 with fetal sex determination
- ☐VAN100 without fetal sex determination

Vanadis® NIPT (Trisomies 21, 18, 13 and sex chromosome anomalies)
- ☐VAN120 with fetal sex determination
- ☐VAN130 without fetal sex determination

! Vanadis - Whole blood in two 10ml Speckled Top Cell Free BCT Tubes required

Required for NIPT Screening (select all that apply)

	Yes	No
Abnormal ultrasound findings in current pregnancy	☐	☐
Positive serum screen in current pregnancy	☐	☐
Patient or father of pregnancy with a family history of chromosome abnormality	☐	☐
Patient or father of pregnancy with history of recurrent pregnancy loss	☐	☐
Previous Pregnancy – Trisomy 21	☐	☐
Previous Pregnancy – Trisomy 18	☐	☐
Previous Pregnancy – Trisomy 13	☐	☐
Previous pregnancy with any chromosome abnormality	☐	☐

If yes to any items, please specify: _____

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

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 informed consent for the testing ordered, including a discussion of the benefits and limitations. I confirm that testing is medically necessary and that test results may impact medical management for the patient. I attest that all information on this TRF is true to the best of my knowledge. My signature applies to the informed consent and/or attached letter of medical necessity.

Signature _____ Date MM/DD/YY
authorized medical professional

FOR INTERNAL USE ONLY
Date Rec'd_____ Rec'd _____
TEMP SPEC COL #TUBES VOL
R/C/F
R/C/F

250 Industry Drive, Pittsburgh, PA 15275 • T 888-VANADIS • F 412-220-0785 • vanadis@perkinelmer.com

PAYMENT INFORMATION

☐ **INSTITUTIONAL BILLING** (Please ensure all fields in Ordering Account section on page 1 are complete)

Billing Account Name | Billing Account Number

Contact Name | Contact Number

☐ **INSURANCE BILLING** (Include a copy of both sides of insurance card)

Insurance Carrier and ID | Prior Authorization # (attach confirmation)

Policy Holder Name | Policy Holder DOB (MM/DD/YY) | Policy Holder Relationship to Patient: ☐Self ☐Parent ☐Spouse ☐Other:_____

Benefit Investigation and Out-of-Pocket Cost Policy

PerkinElmer will contact the patient for any estimated out-of-pocket costs that are greater than $100 USD before proceeding with testing. The patient's sample will be placed on hold (for up to 30 days) until authorization to proceed is received from the patient. If the patient does not respond to PerkinElmer within 30 days to discuss estimated out-of-pocket costs, the test order may be cancelled. Please note that failure by the patient to respond to PerkinElmer in a timely fashion regarding estimated out-of-pocket costs may cause a delay in the receipt of the results report.

Patient Billing Acknowledgement:

By signing this form, I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I hereby authorize PerkinElmer Genetics, Inc. ("PerkinElmer") to bill my designated insurance carrier(s) and share health information as needed for the purposes of billing and reimbursement, and I request that payment of authorized benefits be made on my behalf to PerkinElmer for any services furnished the patient listed above by PerkinElmer. If any insurance benefits are remitted to me for services performed by PerkinElmer for the patient, I will forward said benefits to PerkinElmer. I authorize PerkinElmer to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I agree to pay all charges for services provided by PerkinElmer to the patient which are not covered by my health insurance plan or which I am responsible for payment under my health insurance plan. Furthermore, I grant PerkinElmer permission to share health information with my insurance as needed for the purposes of billing and reimbursement.

Patient Signature_____ Date MM/DD/YY

☐ **PATIENT (SELF) PAYMENT**

By providing payment information, you are authorizing PerkinElmer to process payment at the associated charge for tests ordered. Test cost may be confirmed by calling 877-475-4436. Payment is required prior to test initiation. The patient's sample will be placed on hold (for up to 30 days) until payment is secured. If the patient does not provide payment to PerkinElmer within 30 days, the test order may be canceled. Please note that failure by the patient to respond in a timely fashion to PerkinElmer's attempts to obtain payment may cause a delay in the receipt of the results report.

☐ **CHECK:** $_____ Amount Enclosed (Please make checks payable to: PerkinElmer Genetics, Inc.)

☐ **CREDIT CARD** (Please fill out all information):

Credit Card Number | Card Exp. Date (MM/DD/YY) | CVV | Cardholder Printed Name as Appears on Card | Amount

Credit Card Billing Street Address | City / Town | State | Zip Code

Cardholder Signature | Cardholder Phone

☐ **CONTACT PATIENT FOR PAYMENT INFORMATION**

Mobile Phone | Home Phone

Email Address

CLSRV-FM-061-v5 10/27/2022 250 Industry Drive, Pittsburgh, PA 15275 • T 888-VANADIS • F 412-220-0785 • vanadis@perkinelmer.com

SAMPLE AND DATA RETENTION

Pursuant to laboratory best practices, your sample will be retained by PerkinElmer for a minimum of two years and then destroyed. Additionally, your PHI, the data from the Tests (including those performed before any withdrawal of consent) and the related reports will be retained by PerkinElmer indefinitely, unless otherwise noted. In some instances, it may be beneficial to you for PerkinElmer to retain your sample for a longer period of time in order to conduct additional testing, and PerkinElmer will do so with appropriate documentation from you or your HCP.

PerkinElmer is requesting consent to keep your anonymized sample and data indefinitely for ongoing test development, scientific research, and/or other activities. This consent is optional, and the Test will be performed whether or not you provide consent to the following:

If consent is given for Sample retention, PerkinElmer will anonymize and retain your Sample indefinitely for internal quality control, test validation, assay development and improvement. By allowing PerkinElmer to retain your Sample, you understand and agree that you give up any property rights you may have in the Sample and are donating it to PerkinElmer Genetics, Inc.

If consent is given for data retention, PerkinElmer will anonymize your data and retain the anonymized data and related anonymized reports from your Tests indefinitely for statistical, quality analysis, research, scientific and technical development, and market research. PerkinElmer may also share your anonymized data and anonymized report with third parties."

PerkinElmer is requesting consent to keep your anonymized sample indefinitely for ongoing test development, scientific research, and/or other activities.

☐ Check here if you would like to opt out of anonymized sample retention. Note, if not checked, this is interpreted as "consent given".

PerkinElmer is requesting consent to keep your anonymized data indefinitely for ongoing test development, scientific research, and/or other activities.

☐ Check here if you would like to opt out of anonymized data retention. Note, if not checked, this is interpreted as "consent given".

WITHDRAWAL OF CONSENT

I understand this consent is voluntary and is valid until I withdraw my consent. I understand I may withdraw my consent to sample and data retention, and to the Test at any time, and that PerkinElmer will not perform the Test unless I provide consent to the Test. If I withdraw my consent, it will not affect actions taken before I withdrew my consent, including any anonymization of data or my Sample. I understand that if I wish to withdraw my consent I should contact PerkinElmer via email at: Genomics@perkinelmer.com or toll-free by telephone at +1-866-354-2910 to request withdrawal.

PATIENT CONSENT TO TESTING AND BILLING ACKNOWLEDGEMENT

I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I hereby authorize PerkinElmer Genetics, Inc. ("PerkinElmer") to bill my designated insurance carrier(s) and share health information as needed for the purposes of billing and reimbursement, and I request that payment of authorized benefits be made on my behalf to PerkinElmer for any services furnished the patient listed above by PerkinElmer. If any insurance benefits are remitted to me for services performed by PerkinElmer for the patient, I will forward said benefits to PerkinElmer. I authorize PerkinElmer to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I agree to pay all charges for services provided by PerkinElmer to the patient which are not covered by my health insurance plan or which I am responsible for payment under my health insurance plan. Furthermore, I grant PerkinElmer permission to share health information with my insurance as needed for the purposes of billing and reimbursement.

By signing below I attest that I have read and understood the information in this Patient Informed Consent and I have had my questions about the testing to be performed answered by my healthcare provider. I attest that all information I have provided is accurate, and I consent to PerkinElmer performing the testing ordered by my healthcare provider.

Patient Signature_____ Patient Name_____ Date MM/DD/YY

CLSRV-FM-061-v5 10/27/2022 250 Industry Drive, Pittsburgh, PA 15275 • T 888-VANADIS • F 412-220-0785 • vanadis@perkinelmer.com