Prenatal Genetic Testing Options

Please complete this form **AFTER** you have contacted your insurance and verified coverage for your desired testing. Once sumitted, you can expect to hear back from a Medical Assistant regarding your request within 3-5 business days.

Because it can take up to 3 weeks to obtain a Prior Authorization and some tests are time sensitive, we ask that you complete this form no later than 1 week after your Nurse Intake appointment.

Name *

First Name

Last Name

Birth Date *

MM-DD-YYYY

Date

First Trimester Dating Ultrasound: We recommend an Early Ultrasound around 8-9 weeks of pregnancy to confirm due date and how many babies are growing. This

ultrasound will be scheduled as a seperate appointment that will happen after your RN Intake visit.
This is a screening ultrasound and in the event it, or any other ultrasounds, are not covered by your insurance, you will be responsible for any fees for these services.

*

- ◯ I consent to a first trimester early ultrasound
- ◯ I decline a first trimester early ultrasound

Maternal Screening- Results only show if the mother is a carrier for the following conditions. Please note these do not test baby. For additional information click on the following links: Fragile X Syndrome, Cystic Fibrosis Carrier Screening, Spinal Muscular Atrophy Carrier Screening, and Hemoglobinopathies Screening.

I request that Alliance OB/GYN order and pursue the following testing on my behalf:

Cystic Fibrosis Carrier Screening - Test Codes: 81220 *

- ◯ Cystic Fibrosis Carrier Screening with Prior Authorization
- ◯ Cystic Fibrosis Carrier Screening without Prior Authorization
- ◯ I decline Cystic Fibrosis Carrier Screening

Spinal Muscular Atrophy Carrier Screening - Test Codes: 81329 *

- ◯ Spinal Muscular Atrophy Carrier Screening with Prior Authorization
- ◯ Spinal Muscular Atrophy Carrier Screening without Prior Authorization
- ◯ I decline Spinal Muscular Atrophy Carrier Screening

Hemoglobinopathies Screening - Test Codes: 85660 (Sickle Cell), 81257 (Alpha Thalassemia), 83020 (Beta Thalassemia), 85025 (Standard CBC) *

- ◯ Hemoglobinopathies Screening with Prior Authorization
- ◯ Hemoglobinopathies Screening without Prior Authorization
- ◯ I decline Hemoglobinopathies Screening

Fragile X Syndrome - Test Codes: 81243, 81244 *Not routinely recommended, unless history of premature ovarian failure or family history of Fragile X* *

- ◯ Fragile X Syndrome with Prior Authorization
- ◯ Fragile X Syndrome without Prior Authorization
- ◯ I decline Fragile X Syndrome Screening

Fetal Screening - These tests only screen baby, they do not screen mother. For additional information on the Nuchal Tranlucency Ultrasound or the Free Cell DNA test please click on the following link: Fetal Screening Information

I request that Alliance OB/GYN order and pursue a prior authorization request for the following test on my behalf:

Cell Free DNA - Test Code: 81420, 81507 *

- ◯ Cell Free DNA with Prior Authorization
- ◯ Cell Free DNA without Prior Authorization
- ◯ I decline Cell Free DNA screening

Nuchal Translucency Ultrasound - Test Code: 76813 *

- ◯ Nuchal Translucency Ultrasound with Prior Authorization
- ◯ Nuchal Translucency Ultrasound without Prior Authorization
- ◯ I decline a Nuchal Translucency Ultrasound

Alpha-Fetoprotein - Test Code: 82105 *

- ◯ Alpha Fetoprotein with Prior Authorization
- ◯ Alpha Fetoprotein without Prior Authorization
- ◯ I decline Alpha Fetoprotein screening

* Please note if your insurance is *Blue Care Network*, to verify your benefits you will need to contact JVHL at 800-445-4979 and select option 5

I understand that by selecting and completing these tests I may incur and be responsible for costs not covered by insurance including copays/deductibles/co-insurance.

Signature *

Clear

Submit