

**LCA Use Only.**  
Please place  
accessioning  
sticker here.

# Clinical Questionnaire for Noninvasive Prenatal Testing (NIPT)

Please include this form with sample and order for testing.

## Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**The submission of this form is not an order for a test.** LabCorp may use information obtained on this form and other information provided by the patient and/or ordering provider or his/her designee to initiate preauthorization with the patient's health plan as required. Pretest counseling has occurred with the patient in accordance with their health plan requirements if applicable. The patient understands a preauthorization approval from their health plan does not guarantee full payment.

Patient \_\_\_\_\_ Date \_\_\_\_\_ / Physician \_\_\_\_\_ Date \_\_\_\_\_

## Testing Information (to be completed by provider)

	Test #	CPT		Test #	CPT		Test #	CPT
<input type="radio"/> informaSeq Prenatal Test	550746	81420	<input type="radio"/> MaterniT21 PLUS Core	451927	81420	<input type="radio"/> MaterniT21 PLUS Core+SCA+ESS	451937	81420; 81422
<input type="radio"/> informaSeq With X, Y Analysis	550716	81420	<input type="radio"/> MaterniT21 PLUS Core+ESS	451931	81420; 81422	<input type="radio"/> MaterniT Genome	451941	81420; 81422; 81479
<input type="radio"/> informaSeq With Y Analysis	550757	81420	<input type="radio"/> MaterniT21 PLUS Core+SCA	451934	81420			

## Please check all that apply (to be completed by the provider)

Gestational Age: _____ weeks _____ days	<input type="radio"/> Multiple Gestations	<input type="radio"/> 35 years or older at the time of delivery
Has Patient already had cell-free DNA testing with current pregnancy? <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> History of a prior pregnancy with a trisomy	
<input type="radio"/> Positive first-trimester or second-trimester standard biomarker screening test	<input type="radio"/> Egg donor was used	
<input type="radio"/> Either parent has balanced Robertsonian translocation with an increased risk of fetal trisomy 13 or trisomy 21		
<input type="radio"/> Ultrasonographic findings indicate an increased risk of aneuploidy Findings: _____		

## Laboratory/Facility Information

Testing Laboratory Name: <b>Laboratory Corporation of America Holdings: Center for Molecular Biology and Pathology (CMBP)</b>		
Address/City/State/Zip: <b>1912 TW Alexander Drive; Research Triangle Park, NC 27709 or PO Box 2240; Burlington, NC 27216</b>		
Telephone Number: <b>877-998-7837</b>	Fax Number: <b>888-598-7568</b>	Place of Service: <b>Independent Clinical Laboratory</b>
Email: <b>Preverification@LabCorp.com</b>	TIN #: <b>13-3757370</b>	NPI: <b>1750368700</b>

## Notes