UNITY POWERED BY BillionToOne

Carrier Screen with Reflex NIPT

CFTR • SMN1 • HBB • HBA1 • HBA2

REQUISITION FORM

INSTRUCTIONS

1. Collect the patient's sample by following the instructions in the UNITY™ kit.
2. Place the barcode sticker from box on this form.
3. Complete and place this form in the box along with the sample.

SAMPLE COLLECTION DATE MM-DD-YYYY

PLACE BARCODE HERE

PATIENT INFORMATION *Shaded fields must be completed*

First Name | MI | Last Name

Sex | Date of Birth MM-DD-YYYY

☐ Pregnant, Estimated Due Date MM-DD-YYYY
☐ Twin / Triplet / Surrogate / Egg Donor Pregnancy
☐ Not Pregnant

By providing the info below, I agree to receiving SMS or email related to test status:

Cell Phone | Email Address

Street Address | Apt / Unit / Suite

City | State | Zip Code

Ethnicity *Select all that apply*

☐ Asian
☐ African or African American
☐ Ashkenazi Jewish
☐ French Canadian or Cajun
☐ Hispanic
☐ Northern European
☐ Other
☐ Unknown

Family History *Describe relevant family history or prior testing*

CLINIC INFORMATION *Shaded fields must be completed*

Clinic Name

Clinic Phone | Clinic Fax | Clinic Account Number

Clinic Address

Ordering Healthcare Provider(s) *List and select all that apply*

Genetic Counselor *If applicable*

BILLING INFORMATION *Select one option and provide necessary details*

☐ Bill to Insurance
Includes Medicaid and Tricare

Insurance Company Name | Insurance Group ID

Member ID Number

Policy Owner Name | Policy Owner DOB MM-DD-YYYY

Relationship to Policy Owner *Select one*
☐ Self ☐ Dependent ☐ Other

☐ Bill to Patient

Email Address

CLINICAL INDICATION *Select all that apply. Codes below are not exhaustive, provide additional as necessary.*

Screening for Genetic Disease Carrier Status	☐ Z31.430	☐ Z31.440	
Supervision, Normal 1st Pregnancy	☐ Z34.00	☐ Z34.01	☐ Z34.02
Supervision, Other Normal Pregnancy	☐ Z34.80	☐ Z34.81	☐ Z34.82
Family History	☐ Z84.81	☐ Z84.89	

Other ICD-10 codes: *Include patient's chart notes*

Authorization

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above, (I) certify that the ordered tests are reasonable and medically necessary by the diagnosis or treatment of this patient's condition. (I) certify that, to the extent required by laws of this state in which I provide healthcare services, I have obtained the patient's informed consent to undergo any testing requested herby, and to have the results reported to me and (I) agree to provide you a copy of this person's signed and dated consent per your request.

Physician Signature | Date of Authorization MM-DD-YYYY

PATIENT ACKNOWLEDGEMENT

I hereby authorize the release to BillionToOne (BTO) of any medical and insurance information necessary to process claims for services provided by BTO. I hereby authorize BTO to pursue all necessary appeals of full or partial denials of payment in relation to services provided by BTO.

Patient Signature | Date MM-DD-YYYY

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