UNITY POWERED BY BillionToOne

REQUISITION FORM

1 SELECT TEST PANEL

Samples without a test panel selected will not be processed.

UNITY™ Complete Carrier Screen + Aneuploidy NIPT

☐ **Carrier Screen**
CFTR • SMN1 • HBB • HBA1 • HBA2

Fetal risk assessment will be provided for all positive carrier test results

☐ **Aneuploidy NIPT** for singleton pregnancy
T13 • T18 • T21 • sex chromosome abnormalities

- ☐ order Twin Pregnancy NIPT analysis
- ☐ opt out **fetal sex** (includes aneuploidy NIPT)
- ☐ add **fetal RhD** for RhD-negative mothers (includes aneuploidy NIPT)

SAMPLE REQUIRED: UUU / U / UU

2 SAMPLE COLLECTION DATE & BARCODE

MM-DD-YYYY

PLACE BARCODE HERE

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 first pregnancy	☐ Z34.00	☐ Z34.01	☐ Z34.02
Supervision, other normal pregnancy	☐ Z34.80	☐ Z34.81	☐ Z34.82
Family history	☐ Z84.81	☐ Z84.89	
Family history of intellectual disabilities	☐ Z81.0		
Family history of chromosomal abnormalities	☐ Z82.79		
Antenatal screening for chromosomal anomalies	☐ Z36.0		
Encounter for Rh incompatibility status	☐ Z31.82		
Supervision of elderly primigravida	☐ O09.511	☐ O09.512	☐ O09.513
Supervision of elderly multigravida	☐ O09.521	☐ O09.522	☐ O09.523
Supervision of other high risk pregnancies	☐ O09.891	☐ O09.892	
Abnormal findings	☐ O28.3	☐ O28.5	☐ O28.9

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

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

PROVIDER AUTHORIZATION

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above including the sample redraw and repeat testing when requested by BillionToOne Laboratory, (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.

Provider Signature | Date of Authorization (MM-DD-YYYY)

PATIENT INFORMATION

Shaded fields must be completed.

First Name | MI | Last Name

Sex | Maternal Weight (lbs) | Estimated Due Date (MM-DD-YYYY)

☐ twin ☐ triplets or higher
☐ egg donor / gestational carrier pregnancy
☐ not pregnant

Date of Birth (MM-DD-YYYY)

By providing the information below, I agree I or my provider may be contacted for test status, billing/collection, quality assurance, research or marketing purposes.

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/White ☐ other ☐ unknown

Reported Carrier/Family History

Patient: ☐ alpha thal ☐ sickle cell / HBB ☐ SMA ☐ CF (specify variant)
FOB: ☐ alpha thal ☐ sickle cell / HBB ☐ SMA ☐ CF (specify variant)

Family History:

PATIENT ACKNOWLEDGEMENT

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

Patient Signature | Date of Acknowledgement (MM-DD-YYYY)

CLINIC INFORMATION

Shaded fields must be completed.

Clinic Name

Clinic Phone | Clinic Fax | Clinic Account Number

Additional Notes

BILLING INFORMATION

Select one option and provide necessary details.

☐ **Bill to Insurance**

Attach copy of insurance card

Insurance Company Name | Group ID # | Member ID #

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

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

☐ **Bill to Patient**

Email Address

☐ **Bill to Client**

TEST PANEL	TEST DETAILS	SAMPLE REQUIREMENT
UNITY™ Complete	**Carrier Screen + Aneuploidy NIPT**	**3** x 10 mL tiger-top Streck cell-free DNA BCT® blood tube
	• see conditions below	**Fill to the top (≥ 8mL)**
UNITY™ Carrier Screen	**Carrier Screen** for	**1** x 10 mL tiger-top Streck cell-free DNA BCT® blood tube
Fetal risk assessment will be provided for all positive carrier test results	• **cystic fibrosis** *CFTR* • **spinal muscular atrophy (SMA)** *SMN1* • **hemoglobinopathies (sickle cell disease, alpha / beta thalassemia)** *HBB, HBA1, HBA2*	**Fill to the top (≥ 8mL)**
UNITY™ Aneuploidy	**Aneuploidy NIPT** for	**2** x 10 mL tiger-top Streck cell-free DNA BCT® blood tube
	• **trisomy 21, 18, 13** • **sex chromosome aneuploidy (monosomy X, XXY, XXX, XYY)** • **opt-out fetal sex reporting** • **add fetal Rh(D) reporting**	**Fill to the top (≥ 8mL)**

Fetal risk assessment for recessive conditions (sgNIPT) is only performed on singleton pregnancies ≥10 weeks gestation. sgNIPT cannot be performed for egg donors or gestational carriers.

ICD-10 DIAGNOSIS CODES

Codes below are not exhaustive, provide additional as necessary.

UNITY™ Carrier Screen with Reflex sgNIPT

CPT 81220, 81329

Female for testing for genetic disease carrier status for procreative management	**Z31.430**
Male for testing for genetic disease carrier status for procreative management	**Z31.440**
Supervision of normal first pregnancy, unspecified trimester	**Z34.00**
Supervision of normal first pregnancy, first trimester	**Z34.01**
Supervision of normal first pregnancy, second trimester	**Z34.02**
Supervision of other normal pregnancy, unspecified trimester	**Z34.80**
Supervision of other normal pregnancy, first trimester	**Z34.81**
Supervision of other normal pregnancy, second trimester	**Z34.82**
Supervision of normal pregnancy, unspecified, first trimester	**Z34.91**
Family history of intellectual disabilities	**Z81.0**
Family history of carrier of genetic disease	**Z84.81**
Family history of other specified conditions	**Z84.89**

UNITY™ Aneuploidy NIPT

CPT 81420

Supervision of elderly primigravida, first trimester	**O09.511**
Supervision of elderly primigravida, second trimester	**O09.512**
Supervision of elderly multigravida, first trimester	**O09.521**
Supervision of elderly multigravida, second trimester	**O09.522**
Supervision of other high risk pregnancies, first trimester	**O09.891**
Supervision of other high risk pregnancies, second trimester	**O09.892**
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	**O35.1XX0**
Maternal care for (suspected) chromosomal abnormality in fetus, fetus 1	**O35.1XX1**
Encounter for Rh incompatibility status	**Z31.82**
Encounter for antenatal screening for chromosomal anomalies	**Z36.0**
Family history of chromosomal abnormalities	**Z82.79**

BEFORE YOU SHIP, please ensure that:

- ☑ **Test panel** and **ICD10 codes** are selected
- ☑ **Pregnancy due date** is filled
- ☑ **Insurance card copies** are included (front and back)
- ☑ Requisition is **signed**
- ☑ Tubes are labeled with **name, DOB, collection date**

Call **1-800-463-3339 (1-800-GO FEDEX)** to schedule a pickup