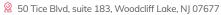


(888) 530-2239

(201) 573-0719







PGT-A Test Requisition

| Patient Information (Fill or attach EMR records) | Ordering Provider |
|--|--|
| First Name | Full Name |
| First NameLast Name | Full NamePhone Fax |
| | PhoneFax |
| Medical Record Number | |
| Street Address City State and 7 in code | |
| CityState and Zip code | |
| Email Address | |
| Phone Number | IVF Lab Contact Information |
| | Lab Contact Name |
| Partner Name | Phone Number |
| DOB / / Biological Sex | Email Address |
| | Ellidi Addiess |
| Clinical Indications | Specimen Information |
| | |
| Advanced maternal age | Specimen Type |
| Multiple failed IVF cycles. Number of prior cycles | Trophectoderm (blastocyst) biopsy. Embryos must be frozen after biopsy, |
| Recurrent pregnancy loss. Number of Miscarriage/IUFDs | PsiGenex cannot accommodate fresh transfers. |
| Male Infertility | |
| Routine Aneuploidy screening | Number of embryo biopsies |
| Personal/ Family planning | Biopsy Dute |
| | Egg Donor? ICSI ? |
| Other | ○ No ○ No |
| | ☐ Yes, donor's age ☐ ☐ Yes, donor's age ☐ ☐ Yes |
| Testing Options | Re-biopsied embryo included ? |
| ☐ PGT for Aneuploidy (PGT-A) ☐ Do not report mosaicism | ○ No ○ Yes, original order ID# |
| | |
| Physician Acknowledgment | Billing Information |
| Confirmation of Informed Consent & Statement of Medical Necessity I affirm each of the following: I have provided genetic testing information to the patient and the patient has consented to genetic testing. This test is medically necessary, and the results will be used in the patient's medical management and treatment decisions. The person listed as the Ordering Provider is authorized by law to order the test(s) requested herein. Provider's Signature | Institutional Billing (Send invoice to facility above) Patient Billing Credit Card #Expiration/ Loan Provider Company Name AddressPolicy Number Prior Auth # Insurance Billing (PGT-A insurance coverage is limited to specific plans) |
| | Insurance Company Name |
| Patient Acknowledgment | Address Policy Holder Name |
| | Policy Holder Relationship to Patient |
| I have read the attached Informed Consent document. I give permission to PsiGenex to perform genetic testing as described. I also give PsiGenex permission to share any relevant personal information with my insurance company for billing purposes. I authorize PsiGenex to bill my insurance company for testing. I understand the benefits and limitations of PGT-A. | Policy NumberPrior Auth # |
| Patient's Signature Date / / | ICD-10 Code(s) |



