UNITY BY BILLIONTOONE

REQUISITION FORM

1 SELECT TEST PANEL

Samples without a test panel selected will not be processed.

UNITY Screen™ **Carrier Screen + NIPT**

SAMPLE REQUIRED: 🧪🧪🧪 🧪 🧪🧪

☐ **Carrier Screen**
CFTR • SMN1 • HBB • HBA

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

☐ **Aneuploidy NIPT** for singleton pregnancy
T13 • T18 • T21 • sex chromosome aneuploidies (Z36.0)

†Includes Aneuploidy NIPT

☐ order twin pregnancy NIPT analysis† (T13, T18, and T21 only)

☐ opt out fetal sex†

☐ add fetal RhD for RhD-negative mothers†

2 SAMPLE COLLECTION DATE & BARCODE

MM-DD-YYYY

PLACE PROVIDED BARCODE HERE

3 CLINICAL INDICATION

Required to select at least one for each test panel. The following codes are not exhaustive.*

UNITY Carrier Screen with fetal risk assessment
If the patient with singleton pregnancy is found to be a carrier for tested disorders, fetal risk assessment will be performed and O28.5 ICD-10 code will be applied.

☐ Family history of carrier genetic disease	Z84.81	
☐ Testing for genetic disease carrier status	Z31.430	Z31.440
☐ Family history of intellectual disabilities	Z81.0	
☐ Other: _____		

UNITY Aneuploidy NIPT *Code determined by trimester of pregnancy.*

☐ 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	O09.893
☐ Supervision, other normal pregnancy	Z34.81	Z34.82	Z34.83
☐ Other: _____			

UNITY RhD NIPT *Code determined by trimester of pregnancy.*

☐ Maternal care for anti-D [Rh] antibodies	O36.011	O36.012	O36.013
☐ Encounter for Rh incompatibility status	Z31.82		
☐ Other: _____			

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

*ICD-10 code selected under one test panel might be used in other test panels' billing.

Ordering Healthcare Provider(s) *

PROVIDER AUTHORIZATION

By submission of this requisition and accompanying sample, I hereby authorize and direct BillionToOne to (1) utilize the above information to process the indicated test for this patient and (2) release the results and patient information to the patient's third-party payer, as needed. I certify (1) all information provided herein is true and accurate, (2) I am authorized by law to request the test, (3) the test is reasonable and medically necessary for the treatment and management of this patient, (4) the patient has been counseled on the potential results, benefits and limitations of the test, and (5) I have obtained informed consent to the extent required under applicable law. I agree to provide the necessary information and medical records to BillionToOne needed to submit and process claims to payers.

Provider Signature * _____ MM-DD-YYYY Date of Authorization

4 PATIENT INFORMATION

First Name * _____ MI _____ Last Name * _____

Sex * _____ Maternal Weight _____ lbs Date of Birth * MM-DD-YYYY Estimated Due Date * MM-DD-YYYY

☐ not pregnant

Pregnancy Details *Select if applicable*

☐ twins ☐ egg donor age of egg donor _____

☐ triplets or higher ☐ gestational carrier pregnancy age of egg donor _____

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

Cell Phone * _____ Email _____

Street Address _____ Apt / Unit / Suite _____

City _____ State _____ Zip Code _____

Ethnicity or Race

☐ Asian ☐ African/African American ☐ Ashkenazi Jewish ☐ Middle Eastern
☐ French Canadian/Cajun ☐ Hispanic ☐ White ☐ other ☐ unknown

Reported Carrier/Family History

Maternal: ☐ alpha thal ☐ sickle cell / HBB ☐ SMA ☐ CF specify variant _____

Paternal: ☐ alpha thal ☐ sickle cell / HBB ☐ SMA ☐ CF specify variant _____

Family History: _____

PATIENT ACKNOWLEDGEMENT

I have been informed of and understand the details of the tests ordered herein for me by my healthcare provider, including the risks, benefits and alternatives, and consented to testing. I understand (1) the test results may inform me of a medical condition that may require follow-up and (2) a negative result does not rule out the possibility of such medical condition in the fetus, myself or my partner. I hereby authorize (1) the release to BillionToOne of any medical and insurance information necessary to process claims and recover reimbursement for services provided by BillionToOne and (2) BillionToOne to pursue all necessary appeals of any denials of payment in relation to services provided by BillionToOne. I understand that the test may not be (1) covered by my insurer/health plan, or (2) deemed medically necessary and I am responsible for any costs not paid by my plan directly to BillionToOne, including any copayments, deductibles or amounts deemed 'patient responsibility'. BillionToOne may contact my healthcare provider to obtain more information regarding clinical correlation and confirmatory testing.

Patient Signature * _____ MM-DD-YYYY Date of Acknowledgement

5 CLINICAL INFORMATION

Clinic Name * _____

Clinic Phone _____ Clinic Fax _____ Clinic Account Number _____

Additional Notes _____

6 BILLING INFORMATION

Select one option and provide necessary details.

☐ Bill to Insurance

Attach copy of insurance card

Insurance Company Name _____

Member ID _____ Group ID _____

Policy Owner _____ Policy Owner DOB MM-DD-YYYY

Relationship to Policy Owner *Select one*

☐ Self ☐ Dependent ☐ Other

☐ Bill to Patient

☐ Bill to Client

UNITY BY BILLION TO ONE

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

Sex chromosome aneuploidies and fetal risk assessment for recessive conditions can only be performed for singleton pregnancies > 10 weeks of gestation. Fetal risk assessment for recessive conditions cannot be performed for egg donors or gestational carriers.

ICD-10 DIAGNOSIS CODES

Codes below are not exhaustive, provide additional codes as necessary.

UNITY Carrier Screen

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 genetic disease	**Z84.81**
Family history of other specified conditions	**Z84.89**

UNITY Aneuploidy

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 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
- ☑ **Required fields** on this form are completed
- ☑ **Insurance card copies** are included (front and back)
- ☑ **Provided barcode** is affixed to tubes and this form
- ☑ Requisition is **signed**

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