

PRENATAL TRIO WHOLE EXOME SEQUENCING REQUISITION
PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Fetus of: _____ Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM / DD / YYYY) _____

Address _____ City _____ State _____ Zip _____ Phone _____

Accession # _____ Hospital / Medical Record # _____

Patient discharged from the hospital/facility: Yes No

Genetic Sex: Female Male Unknown

Gender identity (if different from above): _____

REPORTING RECIPIENTS

Ordering Physician _____ Institution Name _____

Email (Required for International Clients) _____ Phone _____ Fax _____

ADDITIONAL RECIPIENTS

Name _____ Email _____ Fax _____

Name _____ Email _____ Fax _____

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

SELF PAYMENT
 Pay With Sample Bill To Patient

INSTITUTIONAL BILLING

Institution Name _____ Institution Code _____ Institution Contact Name _____ Institution Phone _____ Institution Contact Email _____

INSURANCE

Do not perform test until patient is aware of out-of-pocket costs (excludes prenatal testing)

REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) ICD10 Diagnosis Code(s) (Required)
 3. Name of Ordering Physician 4. Insured Signature of Authorization

Commercial Medicaid Medicare*

*A completed Advance Beneficiary Notice (ABN) is required for Medicare patients that do not meet Medicare criteria.

Has the patient been a hospital inpatient in the last 14 days?

No, the patient was not an inpatient Yes, the patient was an inpatient (hospital stay longer than 24 hours)

Primary Insurance Co. Name _____	Primary Insurance Co. Phone _____	Secondary Insurance Co. Name _____	Secondary Insurance Co. Phone _____
Primary Member Policy # _____	Primary Member Group # _____	Secondary Member Policy # _____	Secondary Member Group # _____
Name of Insured _____	Insured Date of Birth (MM / DD / YYYY) _____	Name of Insured _____	Insured Date of Birth (MM / DD / YYYY) _____
Patient's Relationship to Insured _____	Phone of Insured _____	Patient's Relationship to Insured _____	Phone of Insured _____
Address of Insured _____		Address of Insured _____	
City _____ State _____ Zip _____		City _____ State _____ Zip _____	

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. If self-pay is selected, I agree to pay for the cost of testing ordered and billed by Baylor Genetics as outlined in the Good Faith Estimate I received. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note, Medicare may not cover certain screening tests.

Patient / Guardian Printed Name _____ Patient / Guardian Signature _____ Date (MM / DD / YYYY) _____

PRENATAL TRIO WHOLE EXOME SEQUENCING REQUISITION

 Fetus of: _____
 Patient Last Name Patient First Name MI Date of Birth (MM / DD / YYYY) Genetic Sex

ETHNICITY

- | | | |
|--|---|---|
| <input type="radio"/> African American | <input type="radio"/> Hispanic American | <input type="radio"/> Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia) |
| <input type="radio"/> Ashkenazi Jewish | <input type="radio"/> Mennonite | <input type="radio"/> South Asian (India, Pakistan) |
| <input type="radio"/> East Asian (China, Japan, Korea) | <input type="radio"/> Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey) | <input type="radio"/> Southeast Asian (Vietnam, Cambodia, Thailand) |
| <input type="radio"/> Finnish | <input type="radio"/> Native American | <input type="radio"/> Southern European Caucasian (Spain, Italy, Greece) |
| <input type="radio"/> French Canadian | <input type="radio"/> Northern European Caucasian (Scandinavian, UK, Germany) | <input type="radio"/> Other (Specify): _____ |

TESTING OPTION

-
- 1622 Prenatal Trio Whole Exome Sequencing

GESTATIONAL INFORMATION

NOTE: Providing U/S dating allows for the best handling of the specimen in the lab and improves performance of AFAFP analysis.

 _____ / _____ / _____
 U/S Date (MM / DD / YYYY)

 _____ / _____ / _____
 LMP Date (MM / DD / YYYY)

Gestational Age on U/S Date:

_____ Weeks _____ Days

SAMPLE

 _____ / _____ / _____
 Performing Physician Date of Collection (MM / DD / YYYY)

SAMPLE TYPE

- | | |
|--|---|
| <input type="radio"/> Cultured Amniocytes | <input type="radio"/> Amniotic Fluid ¹ _____ cc |
| <input type="radio"/> Cultured CVS | <input type="radio"/> CVS ¹ _____ mg <input type="checkbox"/> TA <input type="checkbox"/> TC |
| <input type="radio"/> Extracted DNA ² from: _____ | |

1: If direct specimen is submitted, it will be cultured. 2: Extracted DNA is only acceptable from cultured fetal specimen.

Prior to ordering Prenatal Trio WES testing, you must call the lab and discuss the clinical history and sample requirements with a genetic counselor. Please call 1-800-411-4363.

NOTE: Extracted DNA/RNA will only be accepted if the isolation of nucleic acids for clinical testing occurs in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.

 Specimen Requirements/Order Discussed with: _____ / _____ / _____
 Name of Baylor Genetics Genetic Counselor Date of Collection (MM / DD / YYYY)

 Additional Cultures to be sent later: Yes No _____
 Cultures will be sent from (Name of Laboratory)

 Has prior testing been performed at Baylor Genetics? Yes No _____
 If YES, provide Baylor Genetics Family #

BIOLOGICAL PARENTS INFORMATION

BOTH BIOLOGICAL PARENTS SAMPLES ARE REQUIRED. Testing cannot proceed unless BOTH parental samples are received. If BOTH biological parents are not available, then this test CANNOT be ordered. Please call 713-798-6555 to discuss other testing options. Send 10 cc blood in an EDTA tube for each parental sample OR collect with ORACollect•Dx (OCD-100) self-collection kit. Be sure to label parental samples with full name and date of birth - DO NOT LABEL WITH CHILD'S NAME. Must sign parental testing authorization on consent. Turnaround time is 3 weeks AFTER completion of sample culture.

1550 | MATERNAL INFORMATION

-
- Asymptomatic
-
- Symptomatic (Attach summary of findings)

 Maternal Last Name Maternal First Name MI

 _____ / _____ / _____
 Maternal Date of Birth Date of Collection Sample Type:
 (MM / DD / YYYY) (MM / DD / YYYY) Blood Buccal Swab

1550 | PATERNAL INFORMATION

-
- Asymptomatic
-
- Symptomatic (Attach summary of findings)

 Paternal Last Name Paternal First Name MI

 _____ / _____ / _____
 Paternal Date of Birth Date of Collection Sample Type:
 (MM / DD / YYYY) (MM / DD / YYYY) Blood Buccal Swab

ADDITIONAL REPORTING OPTIONS

If a box is not checked the lab will default to No / Not Report.

Option for Reporting of ACMG Secondary Findings for Parents.

Variants in genes included in the ACMG secondary findings guidelines will be reported for each family member marked below. Each marked family member will receive their own report on these findings.

-
- Mother
-
- Father

ITEM CHECKLIST

- | | | |
|---|--|--|
| <input type="checkbox"/> Fetal Sample | <input type="checkbox"/> Consent Form Signed by All Individuals Tested | <input type="checkbox"/> Maternal Sample (EDTA Required) |
| <input type="checkbox"/> Requisition | <input type="checkbox"/> Clinical Note/Summary | <input type="checkbox"/> Paternal Sample (EDTA Required) |
| <input type="checkbox"/> Indication for Study Checklist | <input type="checkbox"/> Pedigree | |

PRENATAL TRIO WHOLE EXOME SEQUENCING REQUISITION

 Fetus of: _____ / _____ / _____
 Patient Last Name Patient First Name MI Date of Birth (MM / DD / YYYY) Genetic Sex

INDICATION FOR TESTING (REQUIRED)

Please provide the following clinical information regarding the patient to be tested. This information is needed to facilitate interpretation of metabolic profiling results. If the laboratory requires additional information, please indicate the healthcare provider to be contacted:

Physician Name Physician Phone ICD-10 Diagnosis Code(s)

INDICATION CHECKLIST

INDICATION	YES*	NO	UNKNOWN
Abdomen Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormality Amniotic Fluid (i.e. Poly, Oligo, Anhyd-dramnios)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distal Extremities Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family History of Similar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fetal Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitalia Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head/Skull Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased Nuchal Translucency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrauterine Growth Restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys and Bladder Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limbs/Long Bones Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung(s) Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macrocephaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microcephaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overgrowth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Placenta and Cord Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spine Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thorax Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* If YES, please provide description below:

IMAGING PERFORMED

- Ultrasound Fetal Echocardiogram
 MRI Other: _____

FETAL GENDER

- Female Ambiguous
 Male Unknown

Please provide details (based on imaging, fetal studies, etc.):

PRENATAL TESTING COMPLETED

TEST	YES*	NO	NORMAL	ABNORMAL*
Aneuploidy FISH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chromosomal Microarray Analysis (CMA)/ Array CGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chromosomes/Karyotype	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Serum Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-invasive Prenatal Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Please provide details for abnormal results:

INFORMED CONSENT FOR PRENATAL TRIO WHOLE EXOME SEQUENCING TESTING

Fetus of: _____ / _____ / _____
Patient Last Name Patient First Name MI Date of Birth (MM / DD / YYYY) Genetic Sex

WHOLE EXOME SEQUENCING (WES) AND WHOLE GENOME SEQUENCING (WGS) CONSENT

This consent form can only be used for whole exome sequencing and whole genome sequencing. Consent forms for other tests are located at Baylor Genetics' website (<https://www.baylorgenetics.com/consent/>).

For the purposes of this consent, "I", "my", "you", and "your" can refer to you, your child, your unborn child, or other individual you are the legal representative of.

TEST INFORMATION

Your healthcare provider (doctor, genetic counselor, or other person with medical training) wants to order a genetic test called Whole Genome Sequencing (WGS) or Whole Exome Sequencing (WES). These tests look for changes, called variants, in a person's DNA that can cause health issues. DNA is our genetic material. These variants can be in certain genes, specific parts of our DNA that are needed for our health. They can also be found in other places in the genome (all DNA that a person has). Based on your known health issues, variants in your DNA that may cause these issues will be reported. This test may explain your health issues. It may also explain health issues that your family may have. Even if this test finds the cause of your health issues, this may not help treat or manage those issues.

Testing where your DNA is compared to one or more family members may be performed. This may help better understand your results or show if your family members have the same variant as you.

Before you sign this consent form, you should speak with your healthcare provider. They can help you understand this testing and what it means for your health.

TEST RESULTS

There are several types of test results that may be reported including:

- **Positive:** A variant in the DNA was found that is related to your health issues or a health issue that you are at an increased risk of having in the future. These changes that cause disease are also known as pathogenic variants.
- **Negative:** No variants in the DNA were found that are related to your health issues or that would increase your risk of a health issue in the future.
- **Variant of Uncertain Clinical Significance (VUS):** A variant in the DNA was found that we do not know its effect, if any, on health. More testing may be needed for you or your family if a VUS is found that may be associated with your health issues.
- **Secondary and Incidental Findings (Optional):** Testing can sometimes find a variant in the DNA not related to the reason for testing but can change your medical care. **Note:** Certain issues within the brain start in adulthood and get worse over time (neurodegenerative). They often have no cure or treatment. By default, these variants will not be reported unless they are related to your health issues. However, variants in one or more of these gene(s) can be requested if needed. Your provider must write each gene needed in your test order.
- **Genes of No Known Disease Association (Optional):** Testing may find a variant in a gene that is not known to cause disease. This may be helpful to learn more about these genes in the future. These results do not currently impact medical management or indicate a diagnosis.

SECONDARY AND INCIDENTAL FINDINGS

The following categories of variants are not expected to cause your current health issues. However, they can each be requested to be reported. Knowing about these variants might affect your future medical care.

- **ACMG Secondary Findings:** The American College of Medical Genetics and Genomics (ACMG) recommends reporting disease-causing variants in certain genes that cause health issues. Each family member can request this group of variants to be reported.
- **Incidental Findings:** Other variants known to cause health issues but that are not causing your current health issues.

CONSIDERATIONS AND LIMITATIONS

- You should speak with your provider before signing this consent form to understand the risks, benefits, and alternatives to testing.
- Testing may show you have, or are at increased chance of having, a health issue. It may show that you have an increased chance of having a child with a health issue.
- Even if the variant(s) causing your health issues are found, how these issues might progress or improve with treatment might not be known. Affected family members with the same variant might not be affected like you are.
- Depending on the results of testing, more testing may be needed to understand these results. This testing might be needed for you and/or other family members.
- A negative result does not rule out the chance for health issues. Our knowledge of variants and how they cause disease may change over time as we learn more about genetics. Testing has limitations to what it can find as well.
- Certain factors may lead to incorrect results. These include mislabeled samples, incorrect information in the test order, and rare technical errors.
- More sample may be needed from you if the first sample is not sufficient to complete testing.

USE OF DATA AND SPECIMEN FOR RESEARCH PURPOSES

Biological specimens, test results, and associated information may be used by Baylor Genetics and its research partners for anonymous or coded research purposes, including improving genetic testing, advancing knowledge of genetic conditions, and developing new technologies, including inclusion in de-identified clinical databases, only with the patient's informed consent. Patient data and specimen will not be used for anonymous or coded research, unless authorized by marking below. A patient's decision to decline participation shall not affect their ability to receive testing from Baylor Genetics.

For Oregon patients, please consult the state specific consent form found at www.baylorgenetics.com/forms.

I authorize Baylor Genetics the use of my specimen and de-identified data for research.

FOR SAMPLES FROM NEW YORK STATE RESIDENTS

Samples from New York State residents shall not be included in research without written consent. Samples will not be retained for more than sixty (60) days after receipt by Baylor Genetics, unless authorized by marking below. No tests other than those authorized shall be performed on the samples.

I authorize Baylor Genetics to retain sample(s) longer based on our retention policy for test development, quality assurance, and training purposes.

INFORMED CONSENT FOR PRENATAL TRIO WHOLE EXOME SEQUENCING TESTING

 Fetus of: _____ / _____ / _____
 Patient Last Name Patient First Name MI Date of Birth (MM / DD / YYYY) Genetic Sex

PATIENT CONFIDENTIALITY AND SAMPLE RETENTION

- If several family members are tested, knowing the correct biological relationships among them is important. In rare cases, testing can show that family members are not related as expected. If this is found, we may contact the provider who ordered your testing.
- If this testing is requested to be cancelled after the order and sample are sent to the laboratory, please see our Test Cancellation Policy at www.baylorgenetics.com/cancel-test/.

PATIENT CONFIDENTIALITY AND SAMPLE RETENTION (CONTINUED)

- Only Baylor Genetics and its contracted partners will have access to your sample for the ordered testing. Results from testing will only be released to: (i) a licensed healthcare provider, (ii) those authorized in writing, (iii) the patient or their personal representative, and (iv) those allowed access to test results by law. You have the right to access your test results from Baylor Genetics by providing a written request. You also have the right to request raw data obtained from your sample by providing a written request or HIPAA Authorization Form.
- In rare cases, people with genetic diseases may have problems with health insurance and employment. The U.S. Federal Government has several laws that prohibit discrimination based on test results by health insurance companies and employers. These laws also prohibit unauthorized disclosure of this information. For more information, please visit www.genome.gov/10002077.
- Samples will be kept in the laboratory based on our retention policy. Once testing is completed, the de-identified sample may be used for test development, quality assurance, and training purposes. Samples are not returned to patients or providers unless requested prior to testing. You and your heirs will not receive payments, benefits, or rights to any resulting products or discoveries.
- The information from your testing may be used in scientific research, publications or presentations, but your specific identity will not be revealed. We may contact your provider to obtain more clinical information about you. Baylor Genetics also performs other types of scientific research and may contact you to see if you would like to be involved.
- Variants found may be submitted to databases. The medical community uses these databases to collect information about how variants might cause disease to improve testing and treatment for patients. An example is ClinVar, a free, public archive of reports on human genetics. Limited clinical information may need to be shared with these databases. In rare cases, this information may be enough to allow you or your family members to be identified.
- For more information on privacy practices at Baylor Genetics, please visit www.baylorgenetics.com/privacy-practices/.

FINANCIAL AGREEMENT

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. I designate Baylor Genetics as my designated representative for purposes of appealing any denial of benefits by my insurance carrier. I irrevocably assign associated payment to Baylor Genetics, and direct that payment be made directly to Baylor Genetics. Please note, some payers may not cover certain screening tests.

If my health insurer does not cover the test or I do not have health insurance, I have received a good faith estimate of the cost for the genetic testing ordered by my provider and agree to pay for the cost of the genetic testing billed to me by Baylor Genetics based on that good faith estimate. More information is available in Baylor Genetics' No Surprises Act and Good Faith Estimate Notice located at <https://www.baylorgenetics.com/no-surprises-act/>.

A Medicare Advance Beneficiary Notice (ABN) is required for services Medicare identifies as not medically necessary.

PATIENT AUTHORIZATION

By signing this statement of consent, I acknowledge that I have read, understand, and hereby grant my informed consent for genetic testing. I have received appropriate explanations from my healthcare provider about the planned genetic test(s) and possible results. I have been informed by my healthcare provider about the availability and importance of genetic counseling and have been provided with written information identifying a genetic counselor or medical geneticist who can provide such counseling services. All my questions have been answered, and I have had the necessary time to make an informed decision about the genetic test(s).

Note: If Prenatal WES was ordered, please leave the Patient section blank and complete only a section for each relative tested below.

I hereby give permission to Baylor Genetics to conduct genetic testing as recommended by my healthcare provider.*

 _____ / _____ / _____
 Patient Name Patient Signature Date Signed (MM / DD / YYYY)

Relationship to Patient	Name	Signature	Date
Relative 1	_____	_____	_____ / _____ / _____
Relative 2	_____	_____	_____ / _____ / _____
Relative 3	_____	_____	_____ / _____ / _____

If one or more family members have a Representative signing on their behalf:

 _____ / _____ / _____
 Name Signature Date (MM / DD / YYYY) Representative For Relationship to Represented Person(s)

*If you are signing on behalf of the patient as the parent(s) and/or person with legal authority to act on behalf of the patient or parent, you may be required to provide evidence of your authority.

INFORMED CONSENT FOR PRENATAL TRIO WHOLE EXOME SEQUENCING TESTING

Fetus of: _____ / _____ / _____
Patient Last Name Patient First Name MI Date of Birth (MM / DD / YYYY) Genetic Sex

FOR SURROGATES PREGNANCIES – FOR PRENATAL WES ONLY:

Maternal cell contamination (MCC) studies use blood or another sample from a pregnant person. MCC studies are used to determine that the sample being tested belongs to the fetus and not the pregnant person. The results of MCC studies are not used for the treatment or management of the fetus, pregnant person, or other individuals, and are not part of the pregnant person's designated medical record.

I hereby give permission for my sample to be used for MCC studies:

Surrogate Name Surrogate Signature _____ / _____ / _____
Date Signed (MM / DD / YYYY)

A. Ordering Physician Name: _____

B. Patient Name: _____ **C. Identification Number:** _____

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for a Baylor Genetics test below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for one or more of the **Baylor Genetics test(s)** below.

D. Laboratory Tests	E. Reason Medicare May Not Pay:	F. Estimated Cost
Prenatal Trio Whole Exome Sequencing	Medicare does not pay for this test for your condition.	\$4,000

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Baylor Genetics test** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

<p>G. OPTIONS: Check only one box. We cannot choose a box for you.</p>
<input type="checkbox"/> OPTION 1. I want the Baylor Genetics Test listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/> OPTION 2. I want the Baylor Genetics Test listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
<input type="checkbox"/> OPTION 3. I don't want the Baylor Genetics Test listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:
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You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.