BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

PRENATAL 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 #)

Multiple gestation? ◯ Yes ◯ No
If yes, sample from fetus _____

Donor used? Please specify: _____

Patient discharged from the hospital/facility: ◯ Yes ◯ No

Genetic Sex: ◯ Female ◯ Male
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)

Note: All reports will be sent via fax except for international recipients.

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

◯ **SELF PAYMENT**

_____ (Guarantor Last Name) _____ (Guarantor First Name)

Guarantor Billing Address

_____ (Street) _____ (City) _____ (State) _____ (Zip)

_____ (Phone) _____ (Email)

◯ **INSTITUTIONAL BILLING**

_____ (Institution Name) _____ (Institution Code) _____ (Institution Contact Name) _____ (Institution Phone) _____ (Institution Contact Email)

◯ **INSURANCE**

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

_____ (Primary Insurance Co. Name) _____ (Primary Insurance Co. Phone)

_____ (Primary Member Policy #) _____ (Primary Member Group #)

_____ (Name of Insured) _____ / _____ / _____ (Insured Date of Birth MM / DD / YYYY)

_____ (Patient's Relationship to Insured) _____ (Phone of Insured)

_____ (Address of Insured)

_____ (City) _____ (State) _____ (Zip)

_____ (Secondary Insurance Co. Name) _____ (Secondary Insurance Co. Phone)

_____ (Secondary Member Policy #) _____ (Secondary Member Group #)

_____ (Name of Insured) _____ / _____ / _____ (Insured Date of Birth MM / DD / YYYY)

_____ (Patient's Relationship to Insured) _____ (Phone of Insured)

_____ (Address of Insured)

_____ (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)

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

PRENATAL WHOLE EXOME SEQUENCING REQUISITION

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

STATEMENT OF MEDICAL NECESSITY AND CONSENT TO TERMS & CONDITIONS FOR TEST ORDER (REQUIRED)

This requisition hereby incorporates the Terms and Conditions of the Laboratory Services found at https://www.baylorgenetics.com/lab-terms-conditions/ or, in the case of international entities, https://www.baylorgenetics.com/terms-conditions-of-the-laboratory-services-international/. This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient, and they have consented to genetic testing.

_____ (Physician's Printed Name) _____ (Physician's Signature) _____ / _____ / _____ (Date MM / DD / YYYY)

ETHNICITY

- ◯ African American
- ◯ Ashkenazi Jewish
- ◯ East Asian (China, Japan, Korea)
- ◯ Finnish
- ◯ French Canadian
- ◯ Hispanic American
- ◯ Mennonite
- ◯ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- ◯ Native American
- ◯ Northern European Caucasian (Scandinavian, UK, Germany)
- ◯ Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- ◯ South Asian (India, Pakistan)
- ◯ Southeast Asian (Vietnam, Cambodia, Thailand)
- ◯ Southern European Caucasian (Spain, Italy, Greece)
- ◯ 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

For products of conception (POC) testing, please utilize the Whole Genome or Exome Sequencing requisition forms.

- ◯ Cultured Amniocytes
- ◯ Cultured CVS
- ◯ Fetal Blood
- ◯ Extracted DNA[2] from: _____
- ◯ Amniotic Fluid[1] _____ cc
- ◯ CVS[1] _____ mg ☐ TA ☐ TC

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

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.

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 #)

_____ (Contact Information)

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

PRENATAL WHOLE EXOME SEQUENCING REQUISITION

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

COMPARATOR INFORMATION

For each comparator sample, send 10 cc blood in an EDTA tube or an ORAcollect®•Dx (OCD-100) self-collection kit. Be sure each comparator sample is labeled with that comparator's full name and date of birth. If information is missing, or the tube label does not match what the provider sent, Baylor Genetics cannot run the test. If there are delays in the receipt of comparator samples by the laboratory, Prenatal WES reporting may also be delayed.

Comparator	Last Name	First Name	Genetic Sex	Date of Birth (MM / DD / YYYY)	Date of Collection (MM / DD / YYYY)	Sample Type	Symptomatic? (Attach summary of findings if Yes)
1550 | Maternal Was an egg donor used for this pregnancy? ◯ Yes ◯ No Is a surrogate / gestational carrier being used for this pregnancy? ◯ Yes ◯ No				___/___/_____	___/___/_____	◯ Blood in EDTA (preferred) ◯ Buccal Swab ◯ Saliva	◯ Yes ◯ No
1550 | Paternal Was a sperm donor used for this pregnancy? ◯ Yes ◯ No				___/___/_____	___/___/_____	◯ Blood in EDTA (preferred) ◯ Buccal Swab ◯ Saliva	◯ Yes ◯ No

ADDITIONAL REPORTING OPTIONS

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

Option for Reporting of ACMG Secondary Findings
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. Please note that this category of findings will not be reported in the fetus.

☐ Maternal ☐ Paternal

ITEM CHECKLIST

☐ Requisition
☐ Indication for Study Checklist
☐ Consent Form Signed by All Individuals Tested
☐ Clinical Note/Summary
☐ Pedigree
☐ Comparator Samples
☐ Gestational Carrier (for MCC studies)
☐ Fetal Sample

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

PRENATAL 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)

This information is needed to facilitate data interpretation. If the laboratory requires additional information, please indicate the healthcare provider to be contacted:

Healthcare Provider _____

ICD-10 Diagnosis Code(s) _____

INDICATION CHECKLIST

INDICATION FOR TESTING:	YES†	NO	UNKNOWN
Prenatal History & Growth (e.g., intrauterine growth restriction, oligohydramnios or polyhydramnios, increased nuchal translucency, abnormal fetal movement)	◯	◯	◯
Brain & Head (e.g., macrocephaly, microcephaly, holoprosencephaly, hydrocephalus)	◯	◯	◯
Craniofacial & Neck (e.g., cleft lip and/or palate, hypertelorism)	◯	◯	◯
Cardiac (e.g., atrial septal defect, ventricular septal defect, tetralogy of Fallot)	◯	◯	◯
Thoracic, Pulmonary & Abdominal (e.g., congenital diaphragmatic hernia, omphalocele)	◯	◯	◯
Genitourinary (e.g., renal agenesis, ambiguous genitalia)	◯	◯	◯
Skeletal & Limbs (e.g., skeletal dysplasia, polydactyly, scoliosis)	◯	◯	◯

INDICATION FOR TESTING:	YES†	NO	UNKNOWN
Advanced Parental Age	◯	◯	◯
Abnormal Previous Testing	◯	◯	◯
Abnormal U/S (specify)	◯	◯	◯
Multiple Pregnancy Losses	◯	◯	◯
Parental Concern	◯	◯	◯
Other Indication (attach report and specify)	◯	◯	◯

† If YES, please provide description below:

PRENATAL TESTING COMPLETED

TEST	NORMAL	ABNORMAL*
Aneuploidy FISH	◯	◯
Chromosomal Microarray Analysis (CMA)/ Array CGH	◯	◯
Chromosomes/Karyotype	◯	◯
Maternal Serum Screening	◯	◯
Non-invasive Prenatal Screening	◯	◯
Other	◯	◯

FETAL SEX

◯ Female ◯ Ambiguous
◯ Male ◯ Unknown

* Please provide details for abnormal results:

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

PRENATAL WHOLE EXOME SEQUENCING REQUISITION

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

PREVIOUS FAMILIAL GENETIC TESTING

Baylor Genetics may be able to evaluate and report on the presence or absence of previously identified variant(s) of interest. To enable this review, complete variant details must be included in the tables below when submitting the order. If the required variant information is incomplete, Baylor Genetics will not be able to provide retrospective interpretation or commentary regarding that variant in the final report.

PERSONAL OR FAMILY HISTORY OF GENETIC TESTING

Does the patient have a personal or family history of genetic testing?

◯ No ◯ Yes (If yes, please complete all fields below.)

Relation to Fetus	Previous Genetic Testing	Results	Baylor Genetics Lab # (if applicable)
◯ Previous Pregnancy ◯ Sibling ◯ Half-Sibling ◯ Parent (Maternal) ◯ Parent (Paternal) ◯ Other: _____		◯ Positive ◯ Negative ◯ Other: _____	

POSITIVE OR VUS RESULTS FROM PREVIOUS GENETIC TESTING

Requirements:

- Required for Sequence Variants: Gene, c. / p., transcript #
- Required for CNVs: Gene, transcript #, exon # or build, coordinates

	Relation to Fetus (e.g., parent, sibling, etc.)	Gene	Transcript #	c. / p. (SNV) or (CNV #)	Build, Coordinates (CNV)	Baylor Genetics Lab # (If testing was not performed at Baylor Genetics, please attach the report.)
1						
2						
3						

SNV: Single-Nucleotide Variant
CNV: Copy Number Variant

Notes:

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

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

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

PRENATAL 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

A genetic test called Whole Genome Sequencing (WGS) or Whole Exome Sequencing (WES) is being ordered by a healthcare provider (doctor, genetic counselor, or other authorized person with medical training) in connection with your ongoing clinical care. The healthcare provider has determined that this testing is medically necessary, and this testing is not available through Baylor Genetics as a direct-to-consumer genetic testing product or service. 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). These tests may identify DNA variants that may be associated with current or future health issues or health issues for other family members. Even if this test identifies DNA variants that are associated with health issues, the results may not help inform clinical decision-making, including diagnosis, prognosis, medical management, and/or treatment of the condition(s) identified.

Testing may compare one or more family members' DNA. This may help better understand the test results or show if family members have the same variant.

Before deciding whether to proceed with testing, a review of this consent between the individual(s) tested and ordering provider is recommended.

TEST REPORTING & RESULTS

- Results from this testing can be grouped into two main categories:
- **Primary Findings** – results reported when there is strong evidence that a genetic change is related to a health condition and matches the person's symptoms or medical concerns.
- **Additional Reporting** – results that are not related to the reason for testing but may be associated with health risks in the future. See the Additional Reporting section below for more information on these categories.
- Based on current scientific knowledge, there are several types of test results that may be reported including:
- **Positive:** One or more variants in the DNA were identified that are expected to cause health issues which are also known as pathogenic or likely pathogenic variants.
- **Negative:** No variants in the DNA were found that are known to cause health issues.
- **Variant of Uncertain Clinical Significance (VUS):** A variant in the DNA was found that we do not know its effect, if any, on health. Additional testing may help us learn whether this change is related to existing health conditions or if it could be important for health information in the future.

ADDITIONAL REPORTING

The following categories of variants are not expected to cause current health issues. However, knowing about these variants might affect future medical care.

- **Incidental Findings:** Other variants known to cause significant health issues but are not related to the reason testing is being performed. These findings will be reported in the fetus as they may provide important health information. The findings reported in the fetus may include information about whether other family members tested have these findings as well.

  Note: Certain issues within the brain start in adulthood and get worse over time (neurodegenerative). They often have no cure or treatment. These variants will not be reported unless they are related to any clinical findings in the fetus.
- **ACMG Secondary Findings (Optional for comparators):** The American College of Medical Genetics and Genomics (ACMG) recommends reporting disease-causing variants in certain genes that cause health issues. For prenatal testing, these variants are not reported for the fetus, but each family member having testing can opt into reporting these variants.

CONSIDERATIONS AND LIMITATIONS

- The ordering provider is responsible for explaining the risks, benefits, and alternatives to testing. Beyond impacting healthcare treatment, it is important to consider that learning about test results may have emotional and psychological effects.
- When a variant(s) is found that is known to cause health issues, the progression of the condition or treatment might not be known. Family members with the same variant might not be affected in the same way.
- 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.
- 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 (e.g.,unassigned familial relationships). If this is found, we may contact the provider who ordered the testing.
- Certain factors may lead to incorrect or less accurate results. These include mislabeled samples, incorrect information in the test order, rare technical errors, or unassigned familial relationships.
- The final test report may not fully reflect the original test order and may be modified based on laboratory policies and procedures (e.g.,unassigned familial relationships, or delays or absence of comparator samples). The reason for any changes may not be detailed in the report; however, the ordering healthcare provider may contact the laboratory for additional information.
- More sample and/or a different type of sample may be needed if the first sample is not sufficient to complete testing.

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

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

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

USE OF DATA AND SPECIMEN FOR RESEARCH PURPOSES

In addition to the permitted uses described above, biological specimens, test results, and associated information also may be used by Baylor Genetics and its research partners for other research and development purposes, including but not limited to improving genetic testing, advancing understanding of genetic conditions, developing new technologies, and training computational models, in addition to inclusion in de-identified clinical databases. Baylor Genetics will take reasonable steps to remove or limit identifying information and to protect patient privacy; however, due to the unique nature of genetic data, complete anonymization cannot be guaranteed.

Data and specimens from individuals tested will not be used for these additional research and development purposes unless authorized by marking below. The individual(s) tested and their heirs will not receive payments, benefits, or rights to any resulting products or discoveries from authorized research and development activities. An individual's decision to decline participation will not affect their ability to receive testing or other services from Baylor Genetics.

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

By checking the box below, I give Baylor Genetics permission to use my specimen and data from this order for research and development purposes.

☐ Opt-in for use of specimen and 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.

PATIENT CONFIDENTIALITY AND SAMPLE RETENTION

- 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/. Once testing has been completed and results have been reported, the test results become part of your clinical medical record maintained by your healthcare provider. Because this testing is ordered in connection with medically necessary clinical care, test results documented in your medical record are subject to applicable medical records retention requirements and generally cannot be deleted from the medical record upon patient request, though you retain the right to request amendment of information you believe to be inaccurate or incomplete under applicable law, including the HIPAA Privacy Rule (45 C.F.R. § 164.526).
- Only Baylor Genetics and its contracted partners will have access to this 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 individual(s) tested or their personal representative, and (iv) those allowed access to test results by law. The individual(s) tested has the right to access their test results from Baylor Genetics by providing a written request. Because this testing is ordered by a healthcare provider for clinical care, state-level direct-to-consumer genetic privacy laws may not apply.
- In rare cases, people with genetic diseases may have problems with health insurance and employment. Certain federal laws may apply to protect genetic information. The Genetic Information Nondiscrimination Act (GINA) primarily protects predictive genetic information (e.g., risk or carrier status before a condition develops). Because this test is ordered for an existing or suspected condition, confirmed diagnoses are generally not covered by GINA. However, GINA may apply to incidental or secondary findings that reveal future health risks.
- Samples will be kept in the laboratory based on our retention policy. Once testing is completed, the biological sample may be destroyed in accordance with applicable state law requirements (e.g., within sixty (60) days for New York residents unless longer retention is expressly authorized). The destruction of a biological sample does not affect the retention of test results in the medical record. De-identified samples may be used for quality assurance and training purposes prior to destruction. Samples are not returned to individuals tested or providers unless requested prior to testing. The individual(s) tested and their heirs will not receive payments, benefits, or rights to any resulting products or discoveries.
- The information from this testing may be used in scientific research, publications or presentations, but the specific identity of any individual will not be revealed. We may contact the ordering provider to obtain more clinical information. Baylor Genetics also performs other types of scientific research and may contact the individual(s) tested to see if they would like to be involved.
- Variants found from testing may be submitted to databases. The medical community uses these databases to collect information about how variants might cause disease and 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 reveal identity.
- For more information on privacy practices at Baylor Genetics, please visit www.baylorgenetics.com/privacy-practices/

FINANCIAL AGREEMENT

When selecting Self Payment, by signing below, I acknowledge that I am paying for the testing ordered from Baylor Genetics on a self-pay basis and I hereby instruct Baylor Genetics not to submit this claim to my insurance carrier. I have received a Good Faith Estimate of the cost for the testing ordered, as required under the No Surprises Act, and I agree to pay Baylor Genetics for the cost of testing as outlined in that estimate. I understand that payment is my sole responsibility, and I have instructed Baylor Genetics to not submit a claim to Medicare, Medicaid, or any private insurer on my behalf.

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

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

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

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).

Genetic testing is voluntary. I may decline or withdraw consent at any time before results are reported, in accordance with Baylor Genetics' Consent Withdrawal Policy at www.baylorgenetics.com/consent-withdrawal/, without penalty or impact to my care. I also understand that, under the 21st Century Cures Act, clinically relevant results may be shared with my treating providers and generally cannot be withheld.

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

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

Complete this section for all individuals undergoing testing to document consent for genetic testing of non-fetal samples (e.g., maternal sample for MCC studies, paternal samples, etc.). The biological mother may be required to provide consent separately for fetal sample testing and for additional non-fetal studies.

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.

FOR SURROGATES PREGNANCIES

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)

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

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.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **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.

☐ **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.

☐ **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:

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.

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.