

Form Completed By*

Patient Last Name*

Patient Date of Birth*
 / /

4. Billing Information

Bill To* (Choose one, to allow correct billing, provide Medi-Cal or other insurance information.)

Insurance Medi-Cal Self Pay

Policy or Medi-Cal #

Group ID

Insurance Provider Name

Relationship to Insured (If patient is not the primary insured, provide insured details which are required for billing.)

Self Spouse Child Other

Insured Last Name

Insured First Name

Insured Date of Birth
 / /

Insured Sex
 Female Male

Insured Phone #
 - -

5. Select One cfDNA Processing Lab Specimen may be sent to an alternative lab, at GDSP discretion.

Natera (Vasistera SNP Based NIPT) Revvity Omics Vanadis cfDNA (Sun Clinical/Allied Labs) Quest Dx (GDSP cfDNA Panel) CL: 94804005

6. Patient Consent

If you give consent to prenatal screening by signing below, your blood will be collected and sent to a state-contracted laboratory for prenatal screening.

- I consent to participate in the California Prenatal Screening Program.*
- I authorize the release of medical and any other information about myself needed for my health insurance claim.*
- I authorize payment of medical benefits to the Genetic Disease Screening Program (GDSP) for services provided to me.*
- I consent to be billed directly for the services provided to me if I do not have health insurance coverage or Medi-Cal.*
- I informed my provider whether to disclose fetal sex through the California Prenatal Screening Program.*

X _____
 Signature of Patient/Authorized Person*

Date*
 / /

Attestation that verbal consent from patient was obtained:

Provider/Representative Name

Relationship to Patient

7. Blood Sample

Blood Draw Facility Name*

Blood Draw Date* / /

Collector's Initials*

Blood Draw Facility Phone #* - -