



<b>FOR INTERNAL USE ONLY</b>	Client #	Draw #	* Indicates Required Information
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**PHYSICIAN INFORMATION**

Practice Name	Physician Provider # (NPI) *
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Address*	City*	State*	ZIP*
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List ALL appropriate Diagnostic Codes * <input type="checkbox"/> V26.29 Procreative Management Other Investigation & Testing	Phone *	FAX *
Other: _____ please see reverse side for additional codes		

Ordering Physician (first and last name) *	Practitioner Signature *
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**PATIENT INFORMATION**

Last Name *	First Name *	MI	SSN *	Primary Phone *	Alternate Phone *
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Address* (Apt # Required *)	City *	State *	ZIP *	Date of Birth *	Gender *
				/ /	<input type="checkbox"/> M <input type="checkbox"/> F

**BILLING / INSURANCE INFORMATION: Failure to complete insurance information may delay or prevent benefits (Medicare/Medicaid not accepted)**

**PLEASE CHECK ONE OF THE FOLLOWING:**  Self Pay  Bill Account  Submit to Insurance ➔ ATTACH COPY OF FRONT & BACK OF PATIENT INSURANCE CARD\*

PRIMARY Insurance Company Name	Plan Type (check one) <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other	Member #	Group #
Address		City	State ZIP Phone

Secondary Insurance Company Name	Phone	Subscriber's Name (if NOT the same as patient)
Member #	Group #	DOB ____ / ____ / ____ SSN

**CREDIT CARD BILLING INFORMATION (For Self-Pay Patients)**

Cardholder's Name (as appears on card) \*

Billing Address *	City *	State *	ZIP + 4 *
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Card Number *	Expiration Date *	/	VIN# (security code) *
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**PLEASE CHECK ONE OF THE FOLLOWING: \***  Visa  Mastercard  AmEx  Discover

I understand that my physician has ordered the indicated testing for me. I authorize ReproSource to release this information if necessary for processing my insurance claim. I authorize that benefits under this claim be paid directly to ReproSource, and I agree to remit to ReproSource any payment for these services made directly to me. If credit card information is provided, I also authorize ReproSource Fertility Diagnostics to charge the specified fees using the credit card information provided above.

FEES AUTHORIZED: \$ _____	➔	Signature *	Date *
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**Available Tests**

- 510  **SDFA (SPERM DNA FRAGMENTATION ASSAY™)**
- 550  **SPERMATOGENIC FAILURE (GENETIC PANEL)**
- 515  YCMD 3.0 (Y Chromosome MicroDeletion v. 3.0)
- 565  Inhibin B
- 415  Karyotype (Male)
- ANTIPHOSPHOLIPID ANTIBODIES**
- 150  APA Report 1.0 Standard Panel  
includes ACA/aCL, APhL®, aβ-GP1
- 160  APA Report 1.0 Expanded Panel  
Standard Panel plus aPE, aPS, aPA, aPG, aPI
- 115  Lupus Anticoagulant
- 125  APTT (Activated Partial Thromboplastin Time)
- GENETICS**
- 405  Karyotype (Female)
- 415  Karyotype (Male)
- 435  Cystic Fibrosis (100 mutations)

- 800  **THROMBOPHILIA PANEL**
- 805  Antithrombin Activity\*\*
- 125  APTT (Activated Partial Thromboplastin Time)
- 815  Factor V (Leiden)-Coag. \*\*
- 820  Fasting Homocysteine
- 825  PAI-1 Activity\*\*
- 830  Protein C Activity\*\*
- 835  Protein S Activity\*\*
- 840  Prothrombin (G20210A PCR)
- \*\* Request Auto-reflex testing if abnormal
- 600  **OVARIAN ASSESSMENT REPORT (OAR)**  
INDEX EVALUATION OF OOCYTE RETRIEVAL  
AMH, Inhibin B Day 3, FSH, LH, Estradiol
- ADDITIONAL OVARIAN RESERVE TESTS**
- 630  AMH (Anti-Müllerian Hormone)
- 620  Inhibin B Day 3

- ADDITIONAL THROMBOPHILIA TESTS**
- 905  Antithrombin Antigen
- 910  Factor V (Leiden) (R506Q PCR)
- 915  MTHFR (C677T/A1298C PCR)
- 920  PAI-1 Antigen
- 925  Protein C Antigen
- 930  Protein S Free Antigen
- 935  Protein S Free/Total Antigen
- 306  **HLA PHENOTYPE PANEL**  
HLA A, B, C, DR, DQα, DQβ
- 320  NK Activation with IVIg
- 325  RIP (Reproductive Immunophenotyping)
- 205  TPO (Thyroperoxidase Ab)
- 225  THAB (Thyroglobulin Ab)
- 210  ANA (Anti-Nuclear Ab's) Screen \*\*
- 230  ANA Profile (includes anti dsDNA/histone Abs)
- \*\*Request Auto-reflex testing to ANA Profile if abnormal

**Specimen Collection**

**A SEPARATE REQUISITION IS REQUIRED FOR EACH PATIENT BEING TESTED**

**ALL PLASMA MUST BE SHIPPED PRIORITY OVERNIGHT ON DRY ICE**

<input type="checkbox"/> Off-Site Blood Draw Service	<input type="checkbox"/> Home Semen Kit
<input type="checkbox"/> Patient Has Collection Kit - DON'T SHIP	<input type="checkbox"/> Home Buccal Swab Kit
Check collection method & fax test requisition to 781.935.3068	

SPECIMEN COLLECTION DATE *	SPECIMEN COLLECTION TIME (AM/PM)*

DATE RECEIVED:

**Diagnosis Codes** For additional information please contact ReproSource Client Services at 800-667-8893

Most health insurance providers cover under core benefits diagnostic services associated with evaluating fertility. However, once the cause of infertility is established, no further infertility diagnostic testing is generally covered under core medical benefits. Lack of state mandated coverage requirements may further restrict coverage once the patient has been diagnosed as infertile. In general, ReproSource tests are designed to help clinicians when first evaluating a couple's procreative capabilities (fertility) and, therefore, **most ReproSource tests should be covered under the core insurance benefits of most patients' insurance plans if appropriate ICD-9 coding is used.**

Frequently, less appropriate ICD-9 codes for infertility are used because a couple may be presenting with inability to have a child. Without individual investigation of the man and woman, however, it is unclear if one or both are infertile. Therefore, ReproSource tests are designed to help in the initial procreative management evaluation of a couple with difficulty with having a child to determine if there is a diagnosis of infertility in the man or woman.

It is important to note that, although most providers cover services related to establishing infertility as part of core services, some may limit the types of tests that can be used to establish diagnosis. The more applicable codes that are provided, the more likely the patient will receive benefits coverage. Thus, listing as many applicable codes as possible will maximize your patient's chance of having appropriate insurance coverage.

**Example codes for investigating fertility or general disorders (usually covered under core insurance benefits)**

V26.29 Procreative Management, Other investigation and testing  
 V26.21 Procreative Management Fertility testing (sperm count, fallopian tube insufflation)  
 V77.6 Cystic Fibrosis

**Example codes for managing infertility (insurance coverage usually determined by state mandate)**

646.33 Habitual Aborter (Currently Pregnant)	606.1 Oligospermia
629.81 Habitual Aborter (without current pregnancy)	257.2 Other testicular hypofunction
256.8 Ovarian Dysfunction (Other)	758 Chromosomal Anomalies
256.3 Ovarian Failure (Other)	795.7 Nonspecific Immunological Findings (Other)
256. Ovarian Hypofunction	279.80 Other specified disorder
606.0 Azoospermia	

The above is a partial list of commonly used ICD-9 CM codes and descriptions which are from the official code set, issued by the US Department of Health and Human Services, effective 2004 through September 2007. Please refer to the ICD-9CM manual for a complete listing. The ultimate responsibility for the provision of correct diagnosis code(s) lies with the ordering physician. The ordering physician must always determine, for the specific date of service, the appropriate diagnosis code(s) based on the patient's signs and symptoms. ICD-9CM codes are required by certain third-party payers to confirm the medical necessity of the test(s) and/or profile(s) ordered.

**Physicians are asked to submit ALL medically appropriate ICD-9 CM codes when ordering laboratory testing.**