PreTRM®
Test for Risk Management

Test Request Form

LabCorp account number: **43702170**
Test number: **830395**

REQUIRED FOR ORDERING HEALTHCARE PROVIDER
REQUIRED FOR SPECIMEN COLLECTION/PHLEBOTOMY

FOR SPECIMEN COLLECTION USE ONLY

SPECIMEN LABEL HERE

Ordering Healthcare Provider Information

Ordering Healthcare Provider		Healthcare Organization Name	
NPI		Primary Office Contact	
Contact Phone	Secure Fax	Primary Contact Email	
Address		State	ZIP

Patient Information

Last Name	First Name	M.I.
Birth Date	Patient Sex ◯ F ◯ M	MRN or Patient ID
Address		
City	State	Zip
Cell or Primary Phone *(used to contact patient for support or billing)*	Email *(used to contact patient for support or billing)*	

Patient Clinical Information & Intended Use

Due Date (mm/dd/yyyy)	**Height** (ft. in.)	**Pre-pregnancy Weight** (lbs.)
_____/_____/_____		

Common ICD10 Code(s):

- ☐ **Z34.0** ENC SUPV NORMAL FIRST PREG UNS TRI
- ☐ **Z34.01** ENC SUPV NORMAL FIRST PREG 2 TRI
- ☐ **Z34.02** ENC SUPV OTH NORMAL PREG FIRST TRI
- ☐ **Z34.80** ENC SUPV NORMAL PREG UNS UNS TRI
- ☐ **Z34.81** ENC SUPV NORMAL FIRST PREG 1 TRI
- ☐ **Z34.82** ENC SUPV OTHER NORMAL PREG UNS TRI
- ☐ **Z34.90** ENC SUPV OTH NORMAL PREG SECOND TRI
- ☐ **Z34.91** ENC SUP NORMAL PREG UNS FIRST TRI

☐ **Other ICD10 Code(s)** _____

Billing Information

Billing Options

◯ **Bill Insurance** *(please attach copy of insurance card and fill insurance information below)* ◯ **Self Pay** *(patient will be contacted regarding payment; do not complete billing information below)*

Primary Insured	Subscriber Name (Primary)	Subscriber Address (Primary)	
Patient relationship to policyholder ◯ Self ◯ Spouse ◯ Child ◯ Other:_____	Date of Birth	Group Number (Primary)	Policy Number (Primary)
Secondary Insured	Subscriber Name (Secondary)	Subscriber Address (Secondary)	
Patient relationship to policyholder ◯ Self ◯ Spouse ◯ Child ◯ Other:_____	Date of Birth	Group Number (Secondary)	Policy Number (Secondary)

Test Requested

☑ The **PreTRM® Test** for Risk Management predicts the risk of spontaneous preterm birth (before 37 weeks) in asymptomatic women (no signs or symptoms of preterm labor with intact membranes) ≥18 years old with a singleton pregnancy. The PreTRM Test is performed via a single blood draw between 19wk/1d – 20wk/6d (134 – 146 days) gestation. It is not intended for use in women who have a multiple pregnancy, have a known or suspected fetal anomaly, or are on any form of progesterone therapy after the first trimester.

Ordering Healthcare Provider Attestation

I am a licensed healthcare provider authorized to order PreTRM. I have determined that this test is medically necessary for this patient. I am aware of the limitations and intended use of the PreTRM test. The patient has consented and is eligible to use PreTRM. I acknowledge it may be necessary for Sera Prognostics to directly contact the patient for the purposes of obtaining reimbursement for the test and/or to collect additional samples as appropriate.

_____ Healthcare Provider Signature

_____ Date

Patient Blood Draw Information

Patient blood draw for the PreTRM Test must occur within the window
(from gestational age 19wk/1d - 20wk/6d)

Blood Draw Window:

FROM _____/_____/_____ **TO** _____/_____/_____

Blood samples drawn before or after the window will not be tested.

Fasting is not required.

PHLEBOTOMY INFORMATION (UNLESS CAPTURED BY OTHER ELECTRONIC MEANS)

Draw Site Name	Draw Date / Time	
	_____/_____/_____ _____:_____	☐ AM ☐ PM

SERA PROGNOSTICS®
The Pregnancy Company®

Customer Support: Phone (801) 990-6600 / Fax (801) 990-6601 / support@pretrm.com

Sera Prognostics, Inc., 2749 Parleys Way, Suite 200, Salt Lake City, UT 84109 / / PRETRMTECH-103 / 1-22

Print Copy For Patient