



PERINATAL SERVICES REQUEST FORM

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Please advise your patients that we will contact them to schedule an appointment once we have received the referral and authorization from your office.

Services Requested *Please indicate if needed ASAP

Comprehensive Ultrasound * Indicate if NEW Patient

CPT codes 76805, 76811, 76815, 76816, 76817, 76819, 76820, 76821, 99244

TWINS add CPT codes 76812, 76817, 76820, 76821

Follow Up Ultrasound * Use ONLY if Patient is returning to our office

CPT codes 76805, 76811, 76815, 76816, 76817, 76819, 76820, 76821, 99242

TWINS add 76810, 76815, 76816, 76817, 76820, 76821

Fetal Echo *

CPT codes 76805, 76811, 76815, 76816, 76817, 76820, 76821, 76825, 76827, 93325, 99244

TWINS add 76810, 76812, 76815, 76816, 76820, 76821, 76825, 76827, 93325

Amniocentesis * (Please send prenatal labs)

CPT codes 76946, 59000, 76811, 76815, 99205

Lab codes 82106, 88235, 88269, 88280, 88285, 81229

CVS * (Please send prenatal labs)

CPT codes 59015, 76945, 76801, 76813, 99244

Lab codes 88235, 88267, 88280, 88291, 81229

First Trimester Ultrasound

with NT without NT

CPT codes 76801, 76805, 76813, 76817, 99244

TWINS add CPT codes 76802 + 76814 + 76810

CA PNS FORM #: _____

CA Prenatal Screening Program Positive (Please have patient phone us when you have notified them of results)

Genetic Counseling CPT codes 96040

Perinatal Consult - CPT codes 99244, 76801, 76805, 76811, 76813, 76817

Preconception Consult - CPT code 99244, 76830, 76856

Cerclage 59320, 59325, 59871, 76801, 76811, 79813, 76817, 88244

Consideration for Transfer of Care

Indication: _____

**Referring physician requests additional ultrasound services and consult if ultrasound abnormality detected or additional risk identified.*

Reason for referral (Required)

Date of referral: _____

Referring Physician: _____

Office location: _____

Office phone: _____

Office fax: _____

Patient Name: _____

Date of Birth: _____

EDC: _____

Blood Type _____ Rh _____ AntibodyScreen _____ MCV _____

Patient Cell #: _____

Home #: _____

Insurance Carrier: _____

Subscriber ID # _____

Authorization # _____

**PLEASE FAX A COPY OF INSURANCE CARD, AUTHORIZATION & ANY PRENATAL RECORDS
PLEASE ATTACH A COPY OF THE AUTHORIZATION**

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