LIFELINE MEDICAL ASSOCIATES, LLC
WOMEN'S HEALTHCARE IS OUR LIFE'S WORK.

Comprehensive Care Center

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# PRE CONSEPTION BLOODWORK CONSENT

**Name: _____**

Due to the high volume of patients in our practice, we can NOT take responsibility for checking insurance coverage for everyone's individual plan. It is the patient's responsibility to determine what is covered under your insurance plan. We are providing you with the codes below to call your insurance to find out whether these tests are covered under your plan or not. Any balance due after any testing done will be the patient's responsibility. Please make sure you get a reference number and obtain the name of the person you spoke to when calling your insurance company.

Reference Number for the call: _____

Name of the person you spoke to: _____

We have provided you a list of CPT codes to call your insurance company.
Please use the diagnosis code:
**V26.41 (Preconception Panel) & V82.71 (Genetic Carrier Screening).**
Please check off which testing you are having done.

| | |
|---|---|
| ☐ Hemoglobinopathy | CPT Code: 83021, 85660 |
| ☐ Rubella | CPT Code: 86762 |
| ☐ Varicella Zoster | CPT Code: 86787 |
| ☐ Measles | CPT Code: 86765 |
| ☐ Mumps | CPT Code: 86735 |
| ☐ Cystic Fibrosis | CPT Code: 81220 |
| ☐ Fragile X | CPT Code: 81243 |
| ☐ SMA (Spinal Muscular Atrophy) | CPT Code: 81401 |

By signing this form, you are agreeing to have the following testing done in our office.

I, _____understand that any balance due after having the above listed tests done will be my responsibility.