Preimplantation Genetic Diagnosis Request Form

Please fax the completed form to the applicable plan listed below:

- Tufts Health Plan Commercial Plans; Fax: 617.972.9409
- Tufts Health Public Plans; Fax: 888.415.9055
- Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
- Tufts Health Freedom Plan; Fax: 617.972.9409

1. Member Name:	2. Member ID #:	3. DOB:	
4. Member ID#:	5. Diagnosis(es):	6. ICD Code(s):	
7. Provider Name:	8. NPI #:	9. Provider Phone #:	10. Provider Fax #:
Genetic Counseling Information			
Name of Geneticist/Genetic counselor:	Date of visit:		
Please check off the appropriate criteria for requesting Preimplantation Genetic Diagnosis (PGD):			
A. Member or member's partner is a known carrier of an X-Linked disease. Please list relevant X-linked diseases.			
B. Member or member's partner has any known single gene disorder. Please list relevant single gene disorders.			
C. ☐ Testing for unbalanced chromosome rearrangement in a couple where one of the partners is a carrier of chromosomal inversion or other rearrangement.			
D. In the setting of male infertility: ☐ Testing for CF in the embryo when the female is a known CF carrier (PCR technique preferred). ☐ Testing for unbalanced chromosome rearrangements when the male partner has a known balanced chromosome abnormality or sex chromosome abnormality (FISH technique preferred)			

Completed by: Signature _____ Date: _____

(Printed name)_____ Phone # _____Fax #_____

Provider Services