Kathy E Wolf MD PC
Bringing hope through compassionate healthcare

Cystic Fibrosis Screening

Cystic Fibrosis is one of the most common life threatening genetic disorders in the non-Hispanic Caucasian population. Individuals with Cystic Fibrosis have a lower life span and the most common cause of death is respiratory failure. Because it is becoming increasingly difficult to determine a single ethnicity in a patient and because Cystic Fibrosis can occur in any racial or ethnic group, the American Congress of Obstetricians and Gynecologists advises that all pregnant patients be offered screening for this disorder.

Cystic Fibrosis screening is a blood test and can be included in the bloodwork done at a patient's first OB visit. Because some insurance plans do not cover the cost of this test, patients will be responsible for paying for the test. The cost of the test is approximately $1500. We will help with appealing this charge however there is no guarantee that your insurance company will pay for it.

You have the option of checking first with your insurance company to determine if the cost of Cystic Fibrosis testing is covered. It is your responsibility to return to our office for the testing if you would like to proceed. It is important that the Cystic Fibrosis testing be done in the first 3 months of pregnancy.

If you have been tested for Cystic Fibrosis in the past, you do not need to be re-tested.

Please do not hesitate to ask any questions about this screening test.

When calling your insurance company, you may be asked to provide the following codes:

Diagnosis code (ICD-10): Z31.430 Screening for Cystic Fibrosis

Procedure code (CPT): 81220 CFTR gene analysis common variant

Please check one:

- ☐ I wish to have my blood drawn for the Cystic Fibrosis Carrier screening.
- ☐ I do NOT wish to have the Cystic Fibrosis Carrier screening performed.
- ☐ I would like to contact my health insurance to verify coverage first. I understand that it is my responsibility to request the Cystic Fibrosis screening at my next office visit if I opt to be tested.
- ☐ I have received the Cystic Fibrosis screening in the past and do NOT wish to be re-tested.

Date: _____

Patient Name:_____

Signature:_____