Reset Form

GENETIC TESTING PRIOR AUTHORIZATION FORM

FYI: Review our provider manual criteria references. Submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of the request

Fax form and relevant clinical documentation to:
Clinical Intake at 715.787.7317

For questions, call:
715-631-7443 or 855-931-5265

PATIENT INFORMATION:		
Name:		
Aspirus ID:	PMI:	
Address:		
City:	State:	Zip Code:
Date of Birth:	Phone:	

ORDERING PROVIDER INFORMATION: ☐ IN NETWORK ☐ OUT OF NETWORK		
Ordering Provider Name:		
Clinic Name:	NPI Number (required)*:	
Clinic Address:		
City:	State:	Zip Code:
Phone:	Fax:	

SERVICING PROVIDER INFORMATION: ☐ IN NETWORK ☐ OUT OF NETWORK		
Servicing Provider Name:		
NPI Number (required)*:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Email:		

CONTACT PERSON FOR QUESTIONS:	
Name:	
Phone:	Fax:
Email:	

CPT			
CPT Code(s)	# of Units Requested	Start Date	End Date

ICD-10 Diagnosis Codes				

Description of Request:

CRITERIA FOR GENETIC TESTING

- A personal or family medical history which suggests a genetic mutation that increases the risk of a given medical condition.
- There is documentation (please include) that acknowledge the test results will directly impact the medical management of the patient because:
  - ✓ The disease is treatable and/or preventable.
  - ✓ The results will change the frequency, intensity or type of surveillance or treatment of the condition.
  - ✓ The change in medical management is highly likely to result in reduced risk of morbidity and/or mortality.
- Testing recommendations are in accordance with existing guidelines (e.g., NCCN, ACMG, ACOG, Medicare, Medicaid).
- The testing is FDA/ CLIA approved.
- The testing has been shown to be clinically valid by peer- reviewed literature.
- The patient has not had prior genetic testing for the same disease/ condition (In general, genetic testing should only be performed once in a lifetime).
- The person ordering the test is the provider who will be using the results to manage the patient.
- Documentation included of genetic counseling where clinically appropriate that includes a pedigree, appropriate risk assessment, informed consent, discussion of the tests limitations and the psycho-social implications of the results from one of the following providers who is affiliated with the genetic testing lab:
  - ✓ Board-eligible or board-certified genetic counselors
  - ✓ Medical geneticist
  - ✓ Other provider with expertise in genetics (e.g., oncologists, surgeon, gastroenterologist).

Additional information that may support medical necessity:

☐ I certify that the above criteria are met as supported in the attached medical records. I also attest that this patient/ member has given informed consent for the requested testing and that the results of this testing will be used to directly impact the management of care.

Signature of Ordering Clinician: _____ Date: _____