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.
*If your request is related to a **rare disease**, please use the Rare Disease Prior Authorization form located on the UCare website under provider forms.

Fax form and relevant clinical documentation to:
612-884-2499 or 1-866-610-7215

For questions, call:
612-676-3300 or 1-888-531-1493

E-Mail: HCM_Fax@ucare.org

UCare's Secure E-mail Site

PATIENT INFORMATION:		
Name:		
UCare 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: _____