

Prior Authorization Form

NOTE: Refer to the Provider Manual for additional services requiring Prior Authorization



Fax Form To: 616 942-0024

General Genetic Testing* (For [BRCA](#) please use specific form)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____

Primary Care Physician: _____ PCP Phone: _____ PCP Fax: _____

Has PCP been notified of request? Yes No

Requested By:

Provider Name: _____ Phone: _____ Fax: _____

If requesting Provider is not the PCP, what is the Provider's Specialty? _____

Address: _____ Contact Name: _____

_____ Date of Request: _____

Directed To:

Provider Name: _____ Facility/Laboratory: _____

Address: _____ Address: _____

Provider Phone: _____ Fax: _____ Phone: _____ Fax: _____

Contact Name: _____ Contact Name: _____

Requested Test(s):

Specific test being requested: _____

Application CPT codes: _____

Member's clinical history related to testing being requested:

Family history related to testing being ordered if applicable (please indicate if relationship to member is maternal or paternal, i.e. maternal aunt, paternal cousin):

Relationship: _____ Diagnosis: _____ Age at time of diagnosis _____

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Relationship: _____ Diagnosis: _____ Age at time of diagnosis _____

Other relevant information related to testing being ordered:

Genetic counseling completed on: _____

Name of Certified* Genetic Counselor: _____

Contact Number: _____

*See Medical Policy of Genetic Testing #91540 for specific test criteria and genetic counseling requirements.

ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW