MOLECULAR PATHOLOGY REQUEST FORM

All Molecular Pathology/Genetic/Genomic Testing Requires Prior Authorization

Including but not limited to: Prognostic gene expression profiling techniques, gene and molecular expression assays, testing for inherited susceptibility for a disease.

Complete form and fax to: 1.888.329.8471 or 740.695.5297.

Name of Person Submitting Form:			Phone #:
MEMBER (PATIENT) INFORMATION			
Name:		Date of Birth:	
The Health Plan ID#:		PCP Name:	
REQUESTING PHYSICIAN/PROVIDER		FACILITY/LAB TO PERFORM TEST	
Name:		Name:	
Address:		Address:	
Phone Number:		Phone Number:	
FAX Number:		FAX Number:	
Provider Number:		Provider Number:	
Molecular Pathology Test(s) requested & CPT codes:			
1.		2.	
3.		4.	
DIAGNOSES (List of Codes & Descriptions)			
1.		2.	
3.		4.	
CHECK ONE:	☐ Symptomatic	☐ Asymptomatic	☐ Carrier

Genetic Counseling: The patient was provided information regarding the test and its implications, offered genetic counseling when applicable, and the informed consent is documented in the medical record

completed ☐ anticipated ☐ not completed ☐

Clinical information pertinent to the genetic test(s) is required – (please attach clinicals)

How will results of testing impact care:

YOU MUST ATTACH ALL SUPPORTING CLINICAL INFORMATION (e.g. consultations, significant medical history, significant surgical history, lab reports, progress notes, clinical records/office notes) **PLEASE NOTE: DEPENDING ON THE INFORMATION YOU SUBMIT WE MAY REQUEST FURTHER PATIENT SPECIFIC INFORMATION TO PROCESS THIS REQUEST.** Please FAX the form to The Health Plan at 1.888.329.8471 or 740.695.5297.

Ordering Physician Signature:	
Member/Enrollee Signature:	