

Genetic Testing Prior Authorization Form Page 1 of 1

Please return completed form to the Utilization Management Department at (401)459-6023. Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, <u>www.nhpri.org</u> for more detailed information about this benefit, authorization requirements, and coverage criteria.

	MEMBER INI	FORMATION			
Memb		O #:		Member's DOB:	
PROVIDER INFORMATION					
Provider's Name:		Supplier ID or NPI #:		Date of Request:	
Date of Service:		Previous Auth #:		Place of Service (City/Town)/Facility:	
Provider's Phone #:		Provider's Fax #:		Provider's Contact Name:	
CLINICAL INFORMATION The test must be for the benefit of the member in that the test results will have an impact on and make a change in the member's clinical management. The sensitivity of the test must be greater than the clinical pre-test probability of the diagnosis.					
U	Inits:	CPT Code:		Units:	
Diagnosis: Diagnosis Code:					
1. Is the requested test for a specific genetic defect, such as					
2. If the test is positive how will that affect the					
member's clinical management? 3. If the test is negative, how will that affect the member's clinical management?					
Name of Genetic Test:				Test Code (if applicable):	
Name of LabAddress					
Phone Number:FaxNumber:					
NOTE: THI	S FORM MUST I	BE SIGNED BY A	PHYSIC	CIAN	
Signature of Treating Physician:		Date:			
HOOD DECI	SION - Authorn	ization is not a	guaran	tee of payment.	
vation #: Dates of Service:		Services Approved:			
UM Initials: Notification Date:		☐ Not Approved - Letter to Follow			
	1. Is the reque Fragile X, or Please descr 2. If the test is member's cr 3. If the test is member's cr 4. Is Test FDA Name of General NOTE: THI rsician: HOOD DECI Dates of S	PROVIDER IS Supplier ID or No Previous Auth # Provider's Fax # CLINICAL IN Denefit of the member in that the transport of the member in that the transport of the test is against the please describe. 1. Is the requested test for a special Fragile X, or is it a screening temple as describe. 2. If the test is positive how will member's clinical management in the please describe. 3. If the test is negative, how will member's clinical management in the please describe. 4. Is Test FDA Approved: Name of Genetic Test: NoTE: THIS FORM MUST It resident: HOOD DECISION - Authority Dates of Service:	PROVIDER INFORMATION Supplier ID or NPI #: Previous Auth #: Provider's Fax #: CLINICAL INFORMATION Diagnosis Code: Units: CPT Code 1. Is the requested test for a specific genetic defect, so Fragile X, or is it a screening test, such as the micro Please describe. 2. If the test is positive how will that affect the member's clinical management? 3. If the test is negative, how will that affect the member's clinical management? 4. Is Test FDA Approved: Name of Genetic Test: NOTE: THIS FORM MUST BE SIGNED BY A sician: Date: HOOD DECISION - Authorization is not a Dates of Service: Services Approve	PROVIDER INFORMATION Supplier ID or NPI #: Date of Previous Auth #: Place of Provider's Fax #: Provider CLINICAL INFORMATION Denefit of the member in that the test results will have an impart angement. The sensitivity of the test must be greater than the company of the test in the provider of the test must be greater than the company of the test in that the test results will have an impart angement. The sensitivity of the test must be greater than the company of the test in the provider of th	