

# Genetic Testing Request Form

To request services for Commercial fax to 1-866-558-0789.  
 Requests can be submitted online at any time through **Availity.com**.

Date Submitted: \_\_\_\_\_ Pages attached (include cover and/or form): \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_ Contact Fax #: \_\_\_\_\_

**\*\* Please be sure contact fax number is clear due to HIPAA, since decision letters will be faxed to the provider.**

Member Name:	Member ID Number:
Date of Birth (mm/dd/yy):	Male      Female
Diagnosis (including ICD-9-CM Code):	
Procedure:    Office      Outpatient	
Regarding lab panel tests/or genetic panels: Are these codes part of a panel(s)?      Yes      No	
If part of a panel or panels – what is the name of the panel(s)?	

**Requesting provider information below:**

Requesting Provider:	Provider #:	NPI #:
Telephone #:	Fax #:	
Address:	City:	State/Zip:

Facility:	Facility Provider #:	Facility NPI #:
Facility Telephone #:	Facility Fax #:	
Facility Address:	City:	State/Zip:

**Requested Code:**

**Code Description**


**Codes continue on next page**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

**Requested code (continued):**

**Code description**



By submitting this request, you are confirming that you have provided all clinical information available pertinent to this request and you are requesting the decision be made based on information provided in your submission.

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_