ACCU | REFERENCE MEDICAL LAB

1901 East Linden Avenue, Ste. 4, Linden, NJ 07036
Phone (908) 474-1004 Fax (908) 275-8451
EIN: 201236503 NPI: 1225110497

GENETIC TESTING PRIOR AUTHORIZATION REQUEST FORM

This form must be completed and signed by the **ORDERING PROVIDER** and FAXED, with **CLINICAL DOCUMENTATION**, to **(908) 275-8451**

PATIENT INFORMATION

Insurance	Subscriber ID	Group#

Patient Name (Last Name, First Name)	Patient Phone Number
	( ) -

Patient Address	City	State	Zip Code

REQUESTED TESTING

Test Name	Date of Service	

Type of Test (e.g., mutation panel, full gene, sequencing, gene panel, deletion/duplication)

Note: Requests for testing panels including, but not limited to, multiple genes or multiple conditions, and in cases where a tiered approach/method Is clinically available, are covered only for the number of genes or tests deemed medically necessary to establish a diagnosis.

Gene Mutation being tested for:

Diagnosis (ICD-10 CM) Code(s) to support request for genetic testing

Question	
1. Is the testing being ordered by a board certified medical geneticist or other board certified physician with specific expertise in clinical genetics who is not affiliated with the testing laboratory?	Yes ☐ No ☐
2.Has the individual been evaluated and counseled by a board certified medical geneticist or other board certified physician with specific expertise in clinical genetics who is not affiliated with the testing laboratory? **Please attach three generation pedigree and documentation from the medical record**	Yes ☐ No ☐
3. Has a specific mutation or set of mutations been identified and broadly accepted by credible medical societies to be reliably associated with the condition or defect?	Yes ☐ No ☐
4. Can the genetic disorder be diagnosed or ruled out through means other than genetic testing (e.g. clinical examination, imaging, laboratory testing, or other testing)? **If yes, please explain why the requested test is medically necessary**	Yes ☐ No ☐

CLINICAL PRESENTATION

Question	
1. Does the individual exhibit clinical features of the mutation in question? **If yes, please attach medical record documentation.**	Yes ☐ No ☐
2. Is the individual a prospective parent and the fetus would be at high risk for a specific inheritable disease or defect and outcome of testing is required to determine carrier status of inherited disorders and to guide subsequent reproductive decisions? **If yes, please attach medical record documentation.**	Yes ☐ No ☐
3. Is the individual at direct risk of inheriting a genetic mutation? **If yes, please attach medical record documentation**	Yes ☐ No ☐

HISTORY

1. Has less intensive testing been completed? **If yes, list previous testing and attach results:** Yes ☐ No ☐

Test	Date of Testing	Mutation Identified	Specific Mutation Identified
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	
		Yes ☐ No ☐	

2. Is there a personal history of this diagnosis? **If yes, list history of related diagnoses/disorders:** Yes ☐ No ☐

Diagnosis	Age at Time of Diagnosis

3. Is there a family history of this diagnosis or related disorders? **If yes, list history of related diagnoses/disorders below:** Yes ☐ No ☐

Relationship	Maternal/ Paternal	Diagnosis	Age at Time of Diagnosis	Family member Deceased?	Was Genetic Testing Completed?	Family Mutation? (if known)
	☐M ☐P			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	☐M ☐P			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	☐M ☐P			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	☐M ☐P			Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

4. Does spouse/reproductive partner have a history of known family mutation, disorder, or related disorder? If yes, please describe: Yes ☐ No ☐

5. Does a previous child have a history of known disorder, related disorder or family mutation? If yes, please describe: Yes ☐ No ☐

ETHNICITY

☐Ashkenazi Jewish Ancestry ☐ African American ☐ Asian ☐ Caribbean ☐ Central/South American
☐Eastern European ☐Hispanic ☐ Middle Eastern ☐ Native American ☐ Northern European
☐ Pacific Islander ☐Western European ☐Other: ____________

MEDICAL MANAGEMENT

1. Will test results directly impact the medical management of the individual? Yes ☐ No ☐

2. Is the disease treatable or preventable? **If yes, please describe:** Yes ☐ No ☐

3. Will the results change the frequency, intensity, or type of surveillance or treatment of the condition? **If yes, please describe:** Yes ☐ No ☐

4. Will the results determine avenues of therapy? **If yes, please describe:** Yes ☐ No ☐

5. Will the change in medical management result in a reduced risk of morbidity and/or mortality? Yes ☐ No ☐

6. Will the testing avoid or supplant additional testing? **If yes, please describe:** Yes ☐ No ☐

Note: Review criteria are used as guidelines only. Determinations are based on a person-centered assessment of the individual and their unique clinical needs. Additional information submitted with this request will be considered as part of the medical necessity review process

ORDERING PROVIDER INFORMATION

Ordering Provider NPI:		Ordering Provider Name:
Street Address:		City, State, Zip:
Phone #: ( ) -	Fax #: ( ) -	Contact Name:

Certification Statement: This is to certify that the requested testing is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.
By signing this form, I certify that the member listed above has given informed consent in accordance with the guidelines and risks and that the analysis will be used to direct the medical management of this member.

Physician Signature:	Date:

1901 East Linden Ave. Suite 4, Linden, NJ 07036 · www.accureference.com · T: (908) 474-1004 · F: (908) 474-0032

BRCA Analysis Self – Pay Patient Agreement

Patient's Name (please print)	Insured/Guarantor Name
Insurance company	Member ID Number

This form serves to make you aware that your insurance company, ______________________________ , may not pay for the service(s) described below. The fact that they may not pay for a particular service does not mean that you should not receive it. There is a good reason that your healthcare provider has recommended it.

TEST CODE	DESCRIPTION	PRICE
BRCA	BRCA Analysis	$600.00

Doctor's Note: ______________________________

____

Charges may not be covered for the following reason(s):

- It is a non-covered item or service, your insurance company will not pay for it
- The service is considered experimental or for research use and is not covered
- Other (explain): ______________________________

Patients without any health insurance coverage must pay $600 for Genetic testing.

- ☐ At this time I have no health insurance coverage. I understand that I am responsible for paying all the charges for the lab services performed.
- ☐ I received the self-pay agreement policy from Accu Reference Medical Lab. I have read and fully understand the information provided to me.
- ☐ If I have any questions about my charges, statements or balance due, I understand that I many contact **Accu Reference's Billing Department at 908-474-1004.**

Patient signature ______________________ Date ____/____/____