CarePartners of Connecticut
MEDICARE ADVANTAGE

Genetic and Molecular Diagnostic Testing Authorization Request

For CarePartners of Connecticut Medicare Advantage HMO and PPO plans, please fax the completed form to **857-304-6463**.

Date of request: / /

Required documentation

Submit the following required documentation:

- Completed Genetic and Molecular Diagnostic Testing Authorization Request Form
- Letter of medical necessity from genetic counselor, including pedigree analysis and genetic counselor's recommendation for testing
- Letter of medical necessity which indicates how the test results will be utilized in the medical management of the Member to significantly improve patient/treatment outcome, including diagnostic or therapeutic interventions necessary to address risks to the member's health caused by the suspected genetic disorder
  ***Note*:** Testing solely for the purpose of informing the care or management of Member's family member(s) will not be covered.

***Note*: Failure to complete form entirely and submit required documentation may result in delay of processing**

Member information

Member name: Date of birth: / / Gender: F M

Member ID #

Provider/laboratory information

Provider/laboratory name:

Provider/laboratory NPI # Phone: Fax:

***Note*:** Blood or specimens should not be collected until after the genetics counselor has made a recommendation regarding the test and the request for prior authorization has been approved. Testing must be performed at a contracted lab when available.

Referring physician information

Referring physician name:

Referring physician NPI # Phone: Fax:

Is referring physician an MD geneticist? Yes No

Is referring physician an MD with expertise in treating the targeted disease? Yes No

Date required genetic counseling completed: / /

Is genetic counselor a board certified genetic counselor or MD geneticist? Yes No

Requesting testing

Specific test being requested (*include analytic gene, type of analysis*):

Test: CPT/HCPCS code:

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Diagnosis (ICD-10) to support request for genetic test:

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Reason for genetic test

Screening testing Diagnosis testing Predictive/prognostic testing Drug response testing
Monitoring testing Carrier testing Prenatal testin

Has less intensive testing been completed? Yes No If yes, list previous testing:

Test	Date of testing	Mutation identified?	Specific mutation identified
	/ /	Yes No	
	/ /	Yes No	
	/ /	Yes No	

Personal and family history

Personal history of this diagnosis? Yes No If yes, list history of related diagnoses/disorders:

Diagnosis	Age at time of diagnosis

Family history of this diagnosis or related disorders:

Relationship	Maternal/paternal	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

Prenatal/carrier

Does spouse/reproductive partner have a history of known family mutation, disorder or related disorder? Yes No

If yes, explain:

Does a previous child have a history of known disorder, related disorder of family mutation? Yes No

If yes, explain:

For BRCA testing only

Member's ethnic background (*e.g., Ashkenazi, Western Northern Europe, Asia*):

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