



MOLECULAR DIAGNOSTIC REQUEST

**Prior Authorization requests will only be accepted through electronic submission.
No molecular/genetic testing will be considered for coverage without all fields completed.
All fields are required fields.**

Priority: Standard Expedited Post Service

MEMBER INFORMATION			
Date		Group Number	
Last Name		First Name	
Address	City	State	Zip Code
ID Number	Date of Birth		

PROVIDER INFORMATION			
Name of Provider Ordering Testing			Tax ID
Contact Name			
Address	City	State	Zip Code
Phone Number	Fax Number	NPI	

PATIENT COUNSELING (Must be completed prior to the request)			
Name of Certified Genetic Counselor or Physician			
Facility		Date of Counseling	
Contact Name	Phone Number	Fax Number	

TEST REQUESTED			
Name of specific test(s) with specific genes to be tested			
Diagnosis Code(s)			
CPT Code(s)			
ICD-10 Code(s)		NPI	
Laboratory/Facility		Tax ID	
Address	City	State	Zip Code
Contact Name	Phone Number	Fax Number	
Has the specimen been collected? (<input type="checkbox"/> YES <input type="checkbox"/> NO) If yes, date specimen was collected			

continued on reverse

TEST REQUESTED

Provide the member's personal clinical history that supports the medical necessity of this test. Note: Clinical information that supports the medical necessity of the test and pedigree as it relates to the member must be provided by the ordering physician or board-certified genetic counselor who is NOT affiliated with the testing lab.

How will this affect the member's clinical management? Treatment Plan:

FAMILY HISTORY RELATED TO ORDERED TESTS

Indicate if the relationship to the member is maternal or paternal. (Example: maternal grandmother, maternal cousin, paternal grandfather, etc.)

Relationship	Diagnosis	Age when diagnosed

GUIDELINES (Complete policy available upon request)

1. AultCare requires prior authorization for molecular diagnostic testing. Claims that are received without prior authorization will be denied for not having been prior authorized. Failure to obtain prior authorization is a plan design denial and, therefore, it is not subject to medical review.
2. AultCare utilizes the InterQual Molecular Diagnostics Criteria (InterQual) when reviewing prior authorization requests for coverage of genetic test. If the specific genetic test is not in the InterQual content, Hayes Technology will be accessed.
3. Testing only for the purpose of care or management of the member's family is not covered.
4. The requested test is FDA approved.

BENEFIT OR ORGANIZATION DETERMINATION

Members may be eligible under their Plan for genetic testing and counseling to determine the genetic risk of a disease when documentation is provided by the ordering / treating practitioner that supports ALL OF THE FOLLOWING:

1. Counseling is performed with a physician or certified genetic counselor pre-and post-test; AND
2. The request delineates the diagnosis and specific genes to be tested to establish a diagnosis; AND
3. Testing is done ONLY for those genes deemed medically necessary to establish a diagnosis (Panels are not covered); AND
4. Alternative diagnostic studies to provide a definitive diagnosis risk for the specific genetic disorder are unavailable or results are ambiguous; AND
5. The requested test is clinically valid, based on published peer-reviewed medical literature; AND
6. The member has not had previous genetic testing for the disease; AND
7. Results of genetic testing must directly impact treatment or management of the member as indicated by a Treatment Plan; AND
8. The member meets the InterQual criteria; AND
9. Testing is for the sole care and management of the member only

Signature of Person Completing Form _____

Printed Name _____ Phone Number _____ Date _____