

OSU Health Plan Genetic Testing Prior Authorization Form

 Email completed form with required documentation to: UtilizationManagement.OSUHealthPlan@osumc.edu Or fax to: 614-292-2667

MEMBER INFORMATION	ORDERING PROVIDER INFORMATION	PERFORMING PROVIDER INFORMATION
Name:	Ordering Provider:	Performing Provider or Facility:
	Contact Name:	Contact Name:
DOB:	Phone:	Phone:
ID:	Fax:	Fax:

*Test Requested:

Planned Date	CPT or HCPCS	Name of Specific Test	ICD-10-CM	Purpose of Test**	How will the genetic test results change/impact future medical management of this patient?***

*Requests may require summary notes from a board certified genetic counselor or a medical geneticist (not affiliated with the testing lab) and pedigree. Please provide this documentation if available.

**Supportive documentation required

To be completed by OSU Health Plan:	
Authorization #: _____	Authorized By: _____
Date Span: _____	Phone: _____
Comments:	

This authorization is for medical necessity only. It is not a guarantee of payment. Approval of benefits is subject to premium payments and coverage limitations, including waiting periods where applicable.

NOTE: This message is intended for the use of the individual(s) to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee of agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify the sender immediately and delete the related message.