

## Pre-Authorization for Genomic Testing Form

Internal Use Only WCM MRN: \_\_\_\_\_ Acct #: \_\_\_\_\_

(required for: Bluecross/Blueshield and Cigna)

### Instructions:

1. Please complete all required sections below.
2. Provide a copy of the patient's health insurance card.
3. Complete clinical history and/or Letter of Medical Necessity is required to process the Pre-Authorization Request.
4. Send completed form and supporting medical documentation, and copy of patient insurance card to the Pathology Billing Office by email at [ngsbilling@med.cornell.edu](mailto:ngsbilling@med.cornell.edu) or by fax at 646-962-0477.

A Pathology Billing Department representative will contact the ordering physician regarding the status of the preauthorization. Additional clinical information may be requested by insurance carrier.

<b>Patient's Insurance Information:</b>	
Patient Name:	Date of Birth:
Name of Policy Holder:	Relationship to Patient: <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER
Name & Address of Insurance Company:	
Policy / ID Number:	Group Number:
Secondary Insurance Carrier:	Name of Policy Holder:
Policy Number:	Group Number:

<b>Clinical Information (MANDATORY):</b>	
Clinical Diagnosis:	Date Requested:
Test(s) Requested:	ICD 10 Codes:
Prior Testing:	
Clinical History :	
How will this testing help in patient management?:	
What testing would be necessary if requested test is not performed?:	

<b>Physician Information:</b>		Internal Department:
Requesting Physician Name:		
Address:		Institution:
Email:	Phone:	Fax:

**Insurance Co/Plan:** \_\_\_\_\_ **Contact Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Effective Date:** \_\_\_\_\_ **Currently Active?**  YES  NO **In Network:**  YES  NO **Out of Network Benefits?:**  YES  NO  
**Precert Required:**  YES  NO **Notes:** \_\_\_\_\_  
**Co-Pay\$:** \_\_\_\_\_ **Deductible:** \_\_\_\_\_ **Deductible(s) Met:** \_\_\_\_\_  
**After Deductible has been met, patient responsibility amount:** \_\_\_\_\_ **Out of Pocket Max:** \_\_\_\_\_  
**Additional Comments:** \_\_\_\_\_

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Joint Clinical Genomics Initiative, Clinical Genomics Laboratory  
<https://pathology.weill.cornell.edu/clinical-services/molecular-and-genomic-pathology>  
[ngsinquiry@med.cornell.edu](mailto:ngsinquiry@med.cornell.edu)

Pre Auth 10/17