my Advocate
MEDICARE ADVANTAGE

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 or 715.221.9555
TTY 711
Fax: 715.221.6616

Genetic, Genomic and Molecular Testing

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Laboratory _____
CPT Codes _____
Concert Genetics GTU descriptor _____
Name/Description of the test _____

Laboratory _____
CPT Codes _____
Concert Genetics GTU descriptor _____
Name/Description of the test _____

Laboratory _____
CPT Codes _____
Concert Genetics GTU descriptor _____
Name/Description of the test _____

Laboratory _____
CPT Codes _____
Concert Genetics GTU descriptor _____
Name/Description of the test _____

Does the member display clinical features, or are they at direct risk of inheriting the mutation in question (presymptomatic) ..... ☐ Yes ☐ No

Is the test begin performed at an ACP or CLIA certified lab ..... ☐ Yes ☐ No

Will the result of the test directly impact the treatment being delivered to the member or other Sanford Health Plan members. ..... ☐ Yes ☐ No

The ordering physician is:

- ☐ Board-certified for high-risk obstetrics
- ☐ Board-eligible or certified in clinical genetics
- ☐ Board-certified in hematology and/or oncology
- ☐ Other, list specialty: _____

Outline the medical significance of the testing _____

_____

_____

Outline the medical care that would be required if the genetic testing is not performed _____

_____

_____

Outline the medical care that would be required if the test is done and the result is negative _____

_____

_____

Outline the medical care that would be required if the test is done and the result is positive _____

_____

_____

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Sanford Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Sanford Health Plan
Health Services Department
PO Box 8000
Marshfield, WI 54449-8000
Fax 715-221-6616

If you have any questions, please contact Provider Assistance at 1.800.548.1224.