PRIOR AUTHORIZATION REQUEST

Please send completed form with supporting clinical documentation and/or chart to either:
Email: PriorAuthorization@bioreference.com Fax: 1-201-663-4074

PATIENT INFORMATION *(PLEASE PRINT)*

PATIENT NAME: _____
Last *First*

STREET: _____ APT.#: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ M/F: ___ PHONE NO.: _____

INSURANCE INFORMATION

CARRIER: _____

ID #: _____ GROUP #: _____

INSURANCE PHONE #: _____

ACCOUNT INFORMATION

ACCOUNT NAME: _____

ACCOUNT NUMBER: _____

PHYSICIAN/HEALTHCARE PROVIDER INFORMATION

PHYSICIAN/HEALTHCARE PROVIDER NAME:

_____

PHYSICIAN/HEALTHCARE PROVIDER SIGNATURE:

_____

NPI #: _____

ICD-10 Code(s): _____

Non-Invasive Prenatal Screening:

☐ TH18-5 ClariTest™ Core Non-Invasive Prenatal Screen

☐ TH19-3 ClariTest™ Core Non-Invasive Prenatal Screen with 22q11.2 Microdeletion

Carrier Screening:

☐ J435-9 Cystic Fibrosis ☐ A662-9 InheriGen™ ☐ 6380-0 Spinal Muscular Atrophy (SMA)

☐ J434-2 Expanded Cystic Fibrosis ☐ A659-5 InheriGen™ Plus (includes CF, Fragile X, SMA) ☐ 2383-8 Fragile X

☐ Other: _____

Date genetic counseling completed: _____

Relevant family history if applicable (i.e. history of infertility): _____

_____

Does the patient/reproductive partner have a history of known 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: _____

Previous diagnostic tests and findings: _____

_____

Additional information: _____

_____

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