THE OHIO STATE UNIVERSITY
HEALTH PLAN

Phone: 614-292-4700

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: