



## Genetic and Molecular Testing Prior Authorization Request Form

Submit completed form and supporting documentation to  
[UtilizationManagement.OSUHealthPlan@OSUMC.edu](mailto:UtilizationManagement.OSUHealthPlan@OSUMC.edu) or fax to (614) 292-2667.

<b>General Information</b>		
Covered Person (Patient) Name:	ID Number:	DOB:
<b>Physician or Licensed Genetic Counselor Information</b>		
Name:	Office Contact:	
Phone:	Fax:	
<b>Performing Provider Information</b>		
Provider Name:	Address:	
TIN:	Contact Name:	
Phone:	Fax:	
<b>Clinical Information</b>		
Diagnosis:		
Is the requested test a panel? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide rationale for panel over single-gene testing:	
Name of Specific Test/Panel:	Specific Gene(s) Included in Test/Panel:	
How will the results of the requested test impact the covered person's treatment or clinical management?		
<b>Billing Information</b>		
Date of Service:	ICD-10 Code(s):	
HCPCS Code(s)/Units:		

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.