THE OHIO STATE UNIVERSITY
HEALTH PLAN

Genetic and Molecular Testing Prior Authorization Request Form

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

General Information		
Covered Person (Patient) Name:	ID Number:	DOB:
Physician or Licensed Genetic Counselor Information		
Name:	Office Contact:	
Phone:	Fax:	
Performing Provider Information		
Provider Name:	Address:	
TIN:	Contact Name:	
Phone:	Fax:	
Clinical Information		
Diagnosis:		
Is the requested test a panel? ☐ Yes ☐ 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?		
Billing Information		
Date of Service:	ICD-10 Code(s):	
HCPCS Code(s)/Units:		