GENETIC TESTING PRECERTIFICATION REQUEST FORM

Please complete this form in its entirety and fax to 866.873.8279.

Patient information

Patient's name_____ Cigna ID# _____

Patient's address_____

Date of birth_____ Phone number_____

Requesting health care provider's information

Name_____

Address_____ City/State _____

Taxpayer Identification Number (TIN) _____National Provider Identifier (NPI)_____

Office contact name _____

Phone number _____ Fax number_____

Date of service (if applicable)_____

Laboratory name (if doing institutional billing, please include the name of the performing laboratory)
_____

Address_____ City/State _____

Taxpayer Identification Number (TIN) _____ National Provider Identifier (NPI) _____

Diagnosis description_____

ICD-10 code(s) _____

Is this a panel test? Yes No (circle one)

Proprietary test name(s)/gene name(s)
_____

_____

_____

_____

_____

Procedure code(s) _____