



Genetic Testing Request Form

Please complete this form and submit it as an attachment through one of the following options. Tennessee providers may submit authorization requests at any time in Availity®. Out-of-state providers may submit authorization requests through their provider portal or Cohere®. If you have questions about submitting a prior authorization request, please call **(423) 535-5717, option 2**, or contact your eBusiness Network Manager.

Member Name:	Member ID Number:
Date of Birth (mm/dd/yy):	Male Female
Diagnosis (including ICD-10-CM Code):	

Date Submitted: _____ Pages attached (include cover and/or form): _____

Care Management Contact Name: _____

Phone #: _____ Fax #: _____

Required Information

Completing this section is **required** for review. Please list why the test is being requested. "See attached" or other references **will result in a rejection** of your request.

Indications/Reason for the requested test(s): _____

Blood/tissue collection date: _____ Authorization start date: _____

Requesting provider information below:

Requesting Provider:	Provider #:	NPI #:
Telephone #:	Fax #:	
Address:		
City:	State:	ZIP:

Facility/Lab:	Facility/Lab Provider #:	Facility/Lab NPI #:
Facility/Lab Telephone #:	Facility/Lab Fax #:	
Facility/Lab Address:		
City:	State:	ZIP:

