Neighborhood Health Plan OF RHODE ISLAND™

Genetic Testing
Prior Authorization Form

Please return completed form to the Utilization Management Department at (401)459-6023.
Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, www.nhpri.org for more detailed information about this benefit, authorization requirements, and coverage criteria.

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
PROVIDER INFORMATION		
Provider's Name:	Supplier ID or NPI #:	Date of Request:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:

CLINICAL INFORMATION

The test must be for the benefit of the member in that the test results will have an impact on and make a change in the member's clinical management. The sensitivity of the test must be greater than the clinical pre-test probability of the diagnosis.

CPT Code:	Units:	CPT Code:	Units:

Diagnosis:		Diagnosis Code:
Medical Necessity -	1. Is the requested test for a specific genetic defect, such as Fragile X, or is it a screening test, such as the microarray? Please describe.	
	2. If the test is positive how will that affect the member's clinical management?	
	3. If the test is negative, how will that affect the member's clinical management?	
	4. Is Test FDA Approved:	Yes ☐ No ☐
Genetic Laboratory	Name of Genetic Test:	Test Code (if applicable):

Name of Lab_____
Contact Name:_____Address_____
Phone Number:_____FaxNumber:_____

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Treating Physician:	Date:

NEIGHBORHOOD DECISION - *Authorization is not a guarantee of payment.*

Authorization #:	Dates of Service:	Approved:
UM Initials:	Notification Date:	☐ Not Approved - Letter to Follow