AULTCARE'S PRIMETIME HEALTH PLAN
Phone: (330) 363-7407
Fax: (330) 363-2350

MOLECULAR DIAGNOSTIC REQUEST

NOTE: NO MOLECULAR/GENETIC TESTING WILL BE CONSIDERED FOR COVERAGE WITHOUT ALL FIELDS COMPLETE.
******ALL FIELDS ARE REQUIRED FIELDS.******

MEMBER INFORMATION:

Date: _____ Group Number: _____

Last Name: _____ First Name: _____

Address: _____

ID #: _____ DOB: _____

PROVIDER INFORMATION:

Name of Provider Ordering Testing: _____ Tax ID: _____

Contact Name: _____ Phone: _____ Fax: _____

Address: _____

Patient Counseling (Must be completed prior to request):

Name of certified genetic counselor or physician: _____

Facility: _____ Date of counseling: _____

Contact Name: _____ Phone: _____ Fax: _____

TEST REQUESTED:

Name of specific test(s) with specific genes to be tested: _____

_____

CPT Code(s) _____

ICD-9 (10) Code(s) _____

Laboratory/Facility _____ Tax ID: _____

Address: _____

Contact Name: _____ Phone: _____ Fax: _____

Has the specimen been collected YES____ NO___ If YES, Date collected: _____

Provide the member's personal clinical history that supports the medical necessity of this test. NOTE: Clinical information that supports the medical necessity of the test and pedigree as it relates to the member must be provided by the ordering physician or board certified genetic counselor who is NOT affiliated with the testing lab.

_____

_____

_____

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How will this affect the member's clinical management? Treatment Plan:

_____

_____

_____

_____

_____

Family history related to ordered tests. Indicate if relationship to member is maternal or paternal (example: Maternal grandmother, maternal cousin, paternal grandfather, etc.)

Relationship:_____ Diagnosis:_____ Age when diagnosed:_____

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GUIDELINES (Complete policy available upon request):

1. AultCare requires prior authorization for molecular diagnostic testing. Claims that are received without prior authorization will be denied for not having been prior authorized. Failure to obtain prior authorization is a plan design denial and, therefore, it is not subject to medical review.
2. AultCare utilizes the InterQual Molecular Diagnostics Criteria (InterQual) when reviewing prior authorization requests for coverage of genetic test. If the specific genetic test is not in the InterQual content, Hayes Technology will be accessed.
3. Testing only for the purpose of care or management of the member's family is not covered.
4. The requested test is FDA approved.

BENEFIT OR ORGANIZATION DETERMINATION:

Members may be eligible under their Plan for genetic testing and counseling to determine the genetic risk of a disease when **documentation is provided by the ordering / treating practioner that supports *ALL OF THE FOLLOWING:***

1. Counseling is performed with a physician or certified genetic counselor pre-and post-test; ***AND***
2. The request delineates the diagnosis and specific genes to be tested to establish a diagnosis; ***AND***
3. Testing is done ***ONLY*** for those genes deemed medically necessary to establish a diagnosis (Panels are not covered); ***AND***
4. Alternative diagnostic studies to provide a definitive diagnosis risk for the specific genetic disorder are unavailable or results are ambiguous; ***AND***
5. The requested test is clinically valid, based on published peer-reviewed medical literature; ***AND***
6. The member has not had previous genetic testing for the disease; ***AND***
7. Results of genetic testing must directly impact treatment or management of the member as indicated by a Treatment Plan; ***AND***
8. The member meets the InterQual criteria; ***AND***
9. Testing is for the sole care and management of the member only.

_____

SIGNATURE OF PERSON COMPLETING FORM **PRINTED NAME** **PHONE** **DATE**