Genetic Testing
Fax completed form to: 608-252-0830

PREVEA360 health plan
centered around you

☐ **Pre-Service Non-Urgent (Physician Signature NOT Required)**

☐ **Pre-Service Administratively Urgent (Physician Signature NOT Required)**
(Services which do not meet the definition of Medically Urgent, however, are deemed to be time sensitive by one or more of the affected parties.)

☐ **Pre-Service Medically Urgent (Attending Physician Signature REQUIRED Below)**
(Medically Urgent—In the opinion of the attending physician, there is a risk to the member's life, serious bodily injury or pain that cannot otherwise be managed.)
Attending Physician Signature:_____Date:_____

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION (PCP OR ATTENDING- PROVIDER WHO REFERRED TO GENETICS)		
Provider Name:		Phone #:
Street Address:		Fax #:
City:	State:	Zip Code:
Provider #:	Specialty:	

GENETICS HEALTH CARE PROVIDER INFORMATION CLINICAL GENETICIST, GENETIC COUNSELOR, ADVANCED GENTICS NURSE, GENETIC CLINICAL NURSE, OR ADVANCED PRACTICE NURSE IN GENETICS		
Name:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:

RENDERING LABORATORY INFORMATION		
Name:		TAX PAYER IDENTIFICATION # (TIN)
Street Address:		Fax #
City:	State:	Zip Code:

CLINICAL INFORMATION		
Date (s) of Service:	Diagnosis(s):	ICD Code(s):

Underwritten by Dean Health Plan, Inc.
If you have questions regarding the services or form, please contact Customer Service at 877-230-7555 or review Prevea360's Medical Management site.
Requests to non-plan providers must be approved prior to obtaining services.
Updated: 05/2019

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PREVEA360 health plan℠
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TEST INFORMATION	
Clinical History:	
Requested Test Name(s):	**CPT\HCPCS code(s): (***Required***)**

******Please complete the attached Genetic Counseling Recommendation form if the test you are ordering requires Genetic Counseling***

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Please complete this form if you are the individual providing genetic counseling services necessary to meet the Prevea360 Health Plan medical policy requirements for pre and post genetic counseling requirements for certain tests. Attach this completed form to your online authorization or fax the completed form to 608-252-0830.

To be completed by Genetic Counselor:

Prevea360 Health Plan Authorization Number	
Genetic Counseling Recommendation (choose one of the following):	
☐	This individual meets Prevea360 Health Plan's Medical Coverage Policy Criteria and I support the testing requested.
☐	This individual does not meet Prevea360 Health Plan's Medical Coverage Policy Criteria for the testing requested and I recommend no genetic testing be performed at this time. This request should be denied.
☐	I recommend consideration of other genetic testing not typically approved by Prevea360 Health Plan Medical Policy (Provide explanation below or in the "Additional Information" section of your online authorization):
Genetic Counseling Attestation	
☐	By checking this box and signing below, I affirm that I am a genetic clinical nurse, advanced practice nurse in genetics, board certified genetic counselor, a board-eligibility/board-certified clinical geneticist, or am a participating genetic counselor and I am not currently employed by a genetic testing laboratory.

Signature:	Date:	
Name (Print):	Phone:	Fax:

For further information on genetic testing, please see the Prevea360 Health Plan medical policy titled Genetic Testing MP9012.

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