SFCCN GENETIC TEST REQUEST
SUPPLEMENTAL INFORMATION

Please complete this form and submit along with the SFCCN Medical Authorization Request Form, CMS Special Exemption Form, and supporting clinical documentation. This information will be reviewed by the Medical Director.

Member: _____ **DOB:** _____ **Age:** _____ **Gender:** _____

Requested Test:

Test description (including documentation):

Specificity of test: Sensitivity of test:

Laboratory: Laboratory Phone #:

Address:

Diagnosis Code (s): CPT/HCPS Code (s), if applicable:

Major clinical features:

Previous pertinent lab studies/diagnostic investigations:

Level of actionable consequences of testing (please answer all that are applicable):

Genetic Counseling for future children in family:

Medical monitoring changes:

Treatment considerations:

Life altering changes: