



Common Ground Healthcare Cooperative  
 PO Box 1630  
 Brookfield, WI 53008-1630  
 T: 877.825.9293 | F: 715.221.9749

**Genetic Testing**

**Prior Authorization Request**

Date \_\_\_\_\_

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Provider's office <input type="checkbox"/> Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

**Answer all of the following questions.**

- Does the member display clinical features, or are they at direct risk of inheriting the mutation in question (presymptomatic) .....  Yes  No
- Is the test begin performed at an ACP or CLIA certified lab .....  Yes  No
- Will the result of the test directly impact the treatment being delivered to the member or other CGHC members .....  Yes  No
- Is the individual being tested a CGHC member .....  Yes  No
- Is the ordering physician board-certified for high-risk obstetrics.....  Yes  No
- Is the ordering physician board-eligible or certified in clinical genetics .....  Yes  No

Outline the medical significance of the testing \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Outline the medical care that would be required if the genetic testing is not performed \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Outline the medical care that would be required if the test is done and the result is negative \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Outline the medical care that would be required if the test is done and the result is positive \_\_\_\_\_

---

---

**By signing this form, the provider attests that the above information is accurate and documented in the medical record. CGHC may, at its discretion, request medical records to make a final coverage determination.**

\_\_\_\_\_  
Provider signature

\_\_\_\_\_  
Date

**Pre-service decisions:** Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

**Urgent pre-service decisions:** Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

**Mail or fax form to:** Common Ground Healthcare Cooperative  
PO Box 1630  
Brookfield, WI 53008-1630  
F: 715.221.9749

**If you have any questions, please contact Customer Service at 1.877.514.2442.**