WellFirst Health®

Genetic Testing Authorization form
Fax completed form to: 608-252-0863

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):

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***

The completed form can be faxed to: 608-252-0863
If you have any questions regarding the services or form, please contact the our Customer Care Center at 866-514-4194 or on wellfirstbenefits.com.
An approved prior authorization is required before obtaining services from non-plan providers.
All WellFirst Health products and services are provided by subsidiaries of SSM Health Care Corporation, including but not limited to SSM Health Insurance Company and SSM Health Plan. Provider resources and communications are branded as WellFirst Health.

Genetic Testing Authorization form
Fax completed form to: 608-252-0863

Please complete this form if you are the individual providing genetic counseling services necessary to meet the WellFirst Health 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 608-252-0863.

To be completed by Genetic Counselor:

Genetic Counseling Recommendation (choose one of the following):	
☐	This individual meets WellFirst Health's Medical Coverage Policy Criteria and I support the testing requested.
☐	This individual does not meet WellFirst Health'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 WellFirst Health 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 Genetic Testing page at wellfirstbenefits.com.

The completed form can be faxed to: 608-252-0863
If you have any questions regarding the services or form, please contact our Customer Care Center at 866-514-4194 or on wellfirstbenefits.com An approved prior authorization is required before obtaining services from non-plan providers.
All WellFirst Health products and services are provided by subsidiaries of SSM Health Care Corporation, including but not limited to SSM Health Insurance Company and SSM Health Plan. Provider resources and communications are branded as WellFirst Health.