

GENETIC TESTING PRECERTIFICATION REQUEST FORM



Please complete this form in its entirety and fax to 866.873.8279.

Patient information

Patient's name _____ Cigna ID# _____
Patient's address _____
Date of birth _____ Phone number _____

Requesting health care provider's information

Name _____
Address _____ City/State _____
Taxpayer Identification Number (TIN) _____ National Provider Identifier (NPI) _____
Office contact name _____
Phone number _____ Fax number _____

Date of service (if applicable) _____
Laboratory name (if doing institutional billing, please include the name of the performing laboratory) _____
Address _____ City/State _____
Taxpayer Identification Number (TIN) _____ National Provider Identifier (NPI) _____
Diagnosis description _____
ICD-10 code(s) _____
Is this a panel test? Yes No (circle one)
Proprietary test name(s)/gene name(s) _____ _____ _____ _____
Procedure code(s) _____

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