Genetic Testing Recommendation Form

This form, along with a three-generation pedigree, copy of the ordering health care provider's laboratory requisition form, and a copy of your genetics evaluation documentation are required for consideration of this request. **Please fax the completed form and required copies to Cigna at 1.855.245.1104.**

Customer (patient) information

Name:
Cigna customer ID:
Date of birth:
Date of consultation:

Ordering health care provider information

Name:	Taxpayer Identification Number (TIN):
Street address:	Telephone:
City, State ZIP:	Fax:
Specialty:	

Clinical geneticist, genetic counselor, advanced genetics nurse (AGN-BC), genetic clinical nurse (GCN), or advanced practice nurse in genetics (APNG) information (if different than above)

Name:	
Street address:	Telephone:
City, State ZIP:	Fax:

Rendering laboratory information

Name:	Taxpayer Identification Number (TIN):
Street address:	Telephone:
City, State ZIP:	Fax:

Diagnosis codes

List ICD-10 codes here:

Requested test(s) information

Requested test name(s):	**CPT/HCPCS code(s):**

Recommendation (choose one of the following):

☐	This individual meets Cigna's Medical Coverage Policy criteria, and I support the testing requested.
☐	This individual does not meet Cigna's Medical Coverage Policy criteria, but I support the testing requested for the reason(s) listed below (indicate alternate best practice guidelines that support your recommendation).
☐	I do not support the recommendation, but do recommend consideration of the following alternative testing (provide explanation below).
☐	This individual does not meet Cigna's Medical Coverage Policy criteria for the testing requested, and I recommend no genetic testing be performed at this time.
☐	I have no recommendation to make regarding the testing requested for the reason(s) described below.
	Reasons or explanation:

☐	**By checking this box, I affirm that I am a genetic clinical nurse (GCN), advanced practice nurse in genetics (APNG), board-certified genetic counselor, a board-eligible/board-certified clinical geneticist, or have been specifically credentialed by Cigna to perform genetic counseling, and I am not currently employed by a genetic testing laboratory.**
☐	**By checking this box, I confirm I have attached a three-generation pedigree, copy of the ordering health care provider's lab requisition form, and a copy of my genetics evaluation documentation. I understand authorization may be denied if all documentation is not received.**
☐	**By checking this box, I confirm that I am a breast surgeon and that pre-testing genetic counseling is not being completed due to the urgent need to make a timely surgical decision. I further acknowledge that all other Cigna precertification requirements apply to services performed and that post-genetic testing genetic counseling will be obtained with an appropriately credentialed independent genetic counselor.**

Signature

Signature:	Date: