

# 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:
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## 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:

	<b>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.</b>
	<b>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.</b>
	<b>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.</b>

**Signature**

Signature:	Date:
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