Medicare Advantage Genetic Testing Precertification Request Form

Please complete this form in its entirety and fax to 866.287.5834

CLEAR FORM

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

Requesting health care provider's information			
Name:			
Address:	City:	State:	Zip Code:
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:	Zip Code:
Taxpayer Identification Number (TIN)			
National Provider Identifier (NPI)			
Diagnosis description:			
ICD-10 codes(s):			
Is this a panel test? ☐ Yes ☐ No			
Collection/Completion Date:	Sample Type:		
Proprietary test name(s)/gene name(s):			
Procedure codes(s):			