

# Genetic Testing Recommendation Form



This form, along with a three-generation pedigree, copy of the ordering health care professional'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 professional 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):**

<input type="checkbox"/>	This individual meets Cigna's Medical Coverage Policy criteria, and I support the testing requested.
<input type="checkbox"/>	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).
<input type="checkbox"/>	I do not support the recommendation, but do recommend consideration of the following alternative testing (provide explanation below).
<input type="checkbox"/>	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.
<input type="checkbox"/>	I have no recommendation to make regarding the testing requested for the reason(s) described below.
<input type="checkbox"/>	Reasons or explanation:

<input type="checkbox"/>	<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>
<input type="checkbox"/>	<b>By checking this box, I confirm I have attached a three-generation pedigree, copy of the ordering health care professional'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>

**Signature**

Signature:	Date:
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