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**USE THIS FORM TO REQUEST INSURANCE AUTHORIZATION PRIOR TO SPECIMEN COLLECTION.** THIS IS NOT AN ORDER FOR TESTING.

- » **If submitting a specimen with a request for insurance authorization, do not continue with this form; instead, utilize the appropriate test request form and indicate that insurance authorization is needed.**
  - » **Please note, the ideal time to submit a patient specimen and orders for testing is after all steps below are completed.**
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**To begin the insurance authorization process:**

1. Complete attached form. *The information requested is required by insurance carriers to determine eligibility of coverage for genetic testing.*
2. Include a legible copy of the front and back of the patient's insurance card AND relevant clinic notes.
3. Submit to our Billing Support team by:
  - email (rpsbillingsupport@unmc.edu) using the email button at the bottom of the form
  - or**
  - fax (402-559-8359)

**What to expect after submitting a request:**

4. An 'Insurance Authorization Update' will be sent in nearly all situations to the ordering provider (by the method designated in section D of the attached form.)
5. Testing automatically proceeds if the out of pocket estimate is \$100 or less. Otherwise, we need verbal or written notice from the provider or patient to proceed.
6. The provider is responsible for coordinating specimen collection and shipment to our laboratory.
7. **Continue to form**



# PREAUTHORIZATION INFORMATION FORM

**A. PATIENT INFORMATION**

DATE REQUESTED: \_\_\_\_\_

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ MR#: \_\_\_\_\_

BIOLOGICAL SEX:  Female  Male

PHONE#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

**B. INSURANCE INFORMATION**

**INSURANCE CARD REQUIRED to start authorization**

Insurance card provided (clear, enlarged copy of card - front and back)

Policy Holder is different than the patient

    » POLICY HOLDER NAME: \_\_\_\_\_

    » POLICY HOLDER DOB: \_\_\_\_\_

**C. CLINICAL INFORMATION**

**CLINICAL RECORDS REQUIRED to start authorization**

Records attached (family history, pedigree, previous genetic testing reports)

**D. PROVIDER INFORMATION**

Name: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**Authorization determination will be communicated to you based on your selected preferences below.**

EMAIL me: \_\_\_\_\_

FAX me: \_\_\_\_\_

Send additional email/fax to: \_\_\_\_\_

NOTES: \_\_\_\_\_

**E. SPECIMEN TYPE**

**SPECIMEN TYPE TO BE DRAWN**

<input type="checkbox"/> Amniotic Fluid	<input type="checkbox"/> Chorionic Villi (CVS)
<input type="checkbox"/> POC/Fetal Tissue	<input type="checkbox"/> Blood/Cancer Blood
<input type="checkbox"/> Extracted DNA	<input type="checkbox"/> Solid Tumor
<input type="checkbox"/> Bone Marrow or Core	<input type="checkbox"/> Lymphatic Tissue/Node
<input type="checkbox"/> Tissue/Skin	<input type="checkbox"/> Buccal Mucosa Swab
<input type="checkbox"/> Paraffin Embedded Tissue	<input type="checkbox"/> Urine/Bladder Washings

INDICATIONS FOR TESTING or ICD: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**F. TESTING TO BE AUTHORIZED**

» THIS IS **NOT** AN ORDER FOR TESTING

- Chromosome Analysis
- Chromosome Breakage for Fanconi anemia
- FISH - [specify] \_\_\_\_\_
- Fragile X\*  
*\* performed & reported by Nebraska Medicine Molecular Diagnostic Lab*
- Male Infertility PANEL  
[includes Chromosome Analysis and YCMD]
- Methylation Analysis - Chrom 14  
[Temple synd (Prader-Willi-like), Pat UPD 14]
- Methylation Analysis - Chrom 15  
[Prader-Willi synd, Angelman synd]
- Y Chromosome Microdeletion (for male infertility)
- Cancer Microarray
- High Density SNP Microarray
- Pregnancy Loss Microarray
- Prenatal Microarray

**G. SUBMIT FORM**

**EMAIL:** rpsbillingsupport@unmc.edu

-or-

**FAX:** 402-559-8359