UNMC | REGIONAL PATHOLOGY SERVICES

Regional Pathology Services
University of Nebraska Medical Center
Omaha, Nebraska 68198-7137
www.reglab.org

Toll Free:1.877.560.0009
Phone: 402.559.9480
Fax: 402.559.8359

Cover Page

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.**

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**

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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

- ☐ Amniotic Fluid
- ☐ Chorionic Villi (CVS)
- ☐ POC/Fetal Tissue
- ☐ Blood/Cancer Blood
- ☐ Extracted DNA
- ☐ Solid Tumor
- ☐ Bone Marrow or Core
- ☐ Lymphatic Tissue/Node
- ☐ Tissue/Skin
- ☐ Buccal Mucosa Swab
- ☐ Paraffin Embedded Tissue
- ☐ Urine/Bladder Washings

INDICATIONS FOR TESTING or ICD:

F. TESTING TO BE AUTHORIZED

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

- ☐ **Chromosome Analysis**
- ☐ **FISH -** [specify]
- ☐ **Fragile X**
- ☐ **Male Infertility PANEL** [includes Chromosome Analysis and YCMD]
- ☐ **Methylation Analysis - Chrom 15** *(performed by ARUP)* [Prader-Willi synd, Angelman synd]
- ☐ **Molecular Studies**-[specify]
- ☐ **Y Chromosome Microdeletion (for male infertility)**
- ☐ **Cancer Microarray**
- ☐ **High Density SNP Microarray**
- ☐ **Pregnancy Loss Microarray**
- ☐ **Prenatal Microarray**
- ☐ **OTHER-** [specify]

If known, estimated collection date:

G. SUBMIT FORM

EMAIL: rpsbillingsupport@unmc.edu

-or-

FAX: 402-559-8359

SUBMIT BY EMAIL

END OF FORM ■