Genetic Testing Information

• This form should be completed and attached to all prior authorization requests for genetic testing • All fields marked with an asterisk (*) are required	

Beneficiary Name:*	Medicaid ID#:*
Patient's personal clinical history related to testing:*	
Relevant family history:*	
How will testing outcome(s) inform medical management:*	

If the requested test does not have established criteria, submit publicly accessible data from peer-reviewed, scientific literature and/or national databases that address the clinical validity, predictive value, and/or medical benefit(s) of the specific genetic test(s).

Additional Information