Laboratory of Personalized Genomic Medicine
Department of Pathology and Cell Biology

COLUMBIA UNIVERSITY MEDICAL CENTER

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Pre-Authorization for Genetic Testing Form

Instructions:

Internal Use Only **CUMC MRN**:_____ Acc #:_____

1. Please complete all required sections below,
2. Provide a copy of the patient's health insurance card,
3. A Letter of Medical Necessity is required in order to process the Pre-Authorization Request.
4. Send completed form, Letter of Medical Necessity, supporting medical documentation, and copy of patient insurance card to the Pathology Billing Office by email at or PGMBILLING@cumc.columbia.edu, with cc: CROAuth-Path@cumc.columbia.edu or by fax at **(212)342-3013**.

A Pathology Billing Department representative will contact the ordering physician and/or institution representative regarding the status of the preauthorization.

Patient's Insurance Information:

Patient Name:	Date of Birth:
Name of Policy Holder:	Relationship to Patient: ☐ SELF ☐ PARENT ☐ SPOUSE ☐ CHILD ☐ OTHER
Name & Address of Insurance Company:	
Policy / ID Number:	Group Number:
Secondary Insurance Carrier:	Name of Policy Holder:
Policy Number:	Group Number:

Clinical Information:

Clinical Diagnosis:	Date Requested:
Test(s) Requested:	ICD 10 Codes:
Prior Testing:	
Brief Clinical History & Pedigree (if relevant):	
How will this testing help in patient management?:	
What testing would be necessary if requested test is not performed?:	

Physician Information:

		Internal Department:
Requesting Physician Name:		
Address:		Institution:
Email:	Phone:	Fax:

PGM Billing Use Only:

Insurance Co/Plan:_____ Contact Name:_____ Date:_____

Effective Date: _____ Currently Active? ☐ YES ☐ NO In Network: ☐ YES ☐ NO Out of Network Benefits?: ☐ YES ☐ NO

Precert Required: ☐ YES ☐ NO Notes:_____

Co-Pay$:_____ Deductible:_____ Deductible(s) Met:_____

After Deductible has been met, patient responsibility amount:_____ Out of Pocket Max:_____

Additional Comments:_____