SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY 711

Genetic, Genomic and Molecular Testing

Prior Authorization Request

Date ______________________

Member information		
Member name (print)	SMID	Date of birth (month/day/year)

Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other ______		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number

Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

List the name(s) of the test(s) being requested ______________________

____

____

List the name of the laboratory that will be performing the test ______________________

____

____

List all CPT codes if not listed above ______________________

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____

Does the member display clinical features, or are they at direct risk of inheriting the mutation in question (presymptomatic) . . . . . . ☐ Yes ☐ No

Is the test begin performed at an ACP or CLIA certified lab . . . . . . ☐ Yes ☐ No

Will the result of the test directly impact the treatment being delivered to the member or other Security Health Plan members . . . . . . ☐ Yes ☐ No

The ordering physician is:

- ☐ Board-certified for high-risk obstetrics
- ☐ Board-eligible or certified in clinical genetics
- ☐ Board-certified in hematology and/or oncology
- ☐ Other, list specialty: ______________________

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Outline the medical significance of the testing ____

____

____

Outline the medical care that would be required if the genetic testing is not performed ________________

____

____

Outline the medical care that would be required if the test is done and the result is negative ____________

____

____

Outline the medical care that would be required if the test is done and the result is positive ____________

____

____

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

____ ____________________

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Security Health Plan
Health Services Department
PO Box 8000
Marshfield, WI 54449-8000

Fax 715.221.6616

Marshfield Clinic providers route to:
Health Services Department
Routing location, SHP

If you have any questions, please contact Customer Service at 1.800.548.1224

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