Humana®

Genetic Guidance Program
Fax requests: 1-855-227-0677
Phone requests (Clinical Intake Team):
1-800-523-0023

Genetic/molecular testing preauthorization request

Automated online preauthorization is available for some tests. Please log into the Availity Portal at **Availity.com** for a list of available questionnaires. If the appropriate questionnaire is not available, please complete this form.

Patient demographics:

Patient name:_____ Date of birth:_____/___/_____

Patient's Humana ID number: _____

Phone number: _____

Address: _____

Requesting provider:

Name:_____ Phone number: _____

Address: _____

Tax ID/NPI:_____ Fax number: _____

Laboratory performing testing/servicing provider:

Name: _____ Phone number: _____

Address: _____

Tax ID/NPI:_____ Fax number: _____

Billing provider/referring lab (if different from servicing provider):

Name: _____ Phone number: _____

Address: _____

Tax ID/NPI:_____ Fax number: _____

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Test requested:

Date of service: _____ Test ID: _____

Test name: _____

Diagnosis: _____

ICD codes: _____

CPT codes: _____

Patient history (including age at diagnosis):

_____

_____

Family history, including age at diagnosis, availability for testing (e.g., family member deceased, refused testing or patient not in contact with affected family member) and any genetic testing performed on family member (attach pedigree, if available):

_____

_____

_____

Other findings/testing completed (previous genetic testing for condition):

_____

_____

How will testing be used in relation to treatment or management of the patient?

_____

_____

Is the requested test part of a clinical trial? (Circle one) **Yes No**
If yes, please provide the registration or ID number for the specific trial in which this test is being studied (e.g., ClinicalTrials.gov Identifier: NCT12345678): _____

Person filling out form:

Name: _____ Phone number: _____

Facility: _____