**VERMONT GENETIC TESTING PRIOR AUTHORIZATION FORM**

Please verify whether the genetic testing code(s) require prior authorization prior to submitting. For verification, visit the VT Medicaid Fee Schedule: <http://www.vtmedicaid.com/#/feeSchedule>. Fax completed form and required clinical documentation to 802-879-5963 or email to [AHS.DVHAClinicalUnit@vermont.gov](mailto:AHS.DVHAClinicalUnit@vermont.gov).

Date of Request: \_\_\_/\_\_\_\_/\_\_\_\_\_ Date, if procedure has been scheduled: \_\_\_/\_\_\_\_/\_\_\_\_\_

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| **Member Information** | | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_\_ | Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Gender:  ☐ Female  ☐ Male |

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| **Requesting Provider Information** | | |
| Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provider Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Office Contact Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Office Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Office Contact Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Supplying Provider Information** | | |
| Supplying Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provider Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Facility Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Office Contact Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Office Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Code(s) Information for Requested Genetic Testing** | |
| CPT Code and Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD-10 Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| CPT Code and Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD-10 Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| CPT Code and Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD-10 Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**DVHA does not accept Proprietary Lab Codes (PLA). Please submit the corresponding HCPCS or CPT Code.**

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exception for non-covered codes: Vermont Medicaid will provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions for Medicaid members under age 21.**

**Medical Information**

**What is the suspected diagnosis/es?**

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**Please provide the following clinical documentation with this request form. Failure to submit the required documentation will result in delayed review.**

Documentation that outlines how results of requested test will directly impact the medical management of the member

Results of past related genetic testing performed

Personal or family medical history suggestive of a genetic mutation that may increase the risk of a given medical condition

Supportive literature and/or existing guidelines (i.e. NCCN, ACGM, ACOG)

First tier/gold standard testing and workup have failed to reveal a diagnosis. **Note:** **First-tier/gold standard testing is expected to be completed, when relevant, before subsequent testing is requested. Include results from this testing with the request.**