**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.

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.**