PRIOR AUTHORIZATION

GENETIC TESTING

Note: Prior Authorization DOES NOT guarantee payment or client eligibility

PATIENT INFORMATION		
Name:		Medicaid ID #:
DOB:	Age:	

SECTION 1: SUBMITTING PROVIDER INFORMATION	
Submitting Provider Name:	
Provider NPI#	Taxonomy:
Street Address:	
City, State, Zip Code:	
Telephone:	Contact Name:
SECTION 2: PAY TO PROVIDER INFORMATION (Lab)	
Pay – To Provider Name:	
Pay-To Provider NPI#	Taxonomy:
Street Address:	
City, State, Zip Code:	
Telephone:	Contact Name:
SECTION 3: REQUESTING PHYSICIANS INFORMATION	**Check box if same as Section 1** ☐
Requesting Provider Name:	
Provider NPI#	Taxonomy:
Street Address:	
City, State, Zip Code:	
Telephone:	Contact Name:

SERVICE INFORMATION			
Proposed Dates of Service:		From:	To:
Service Description:	Proc Code	Modifier(s)	Units

REQUIRED ATTACHMENTS

SUPPORTING DOCUMENTATION SHOWING MEDICAL NECESSITY: Please ensure all required documentation is attached to your request at the time of the request. Applicable documentation must be supplied in sufficient detail to satisfy the medical necessity for the service. Additional documentation may be attached when necessary.

Forms can be found on-line at wymedicaid.telligen.com