Genetic Testing

Prior authorization requests accepted from providers only.

Member/patient name: _____

Please provide the following information:

- ☐ Name of the test or gene OR gene sequence or panel
- ☐ For each CPT code include the following description:
  - ☐ The medical condition suspected
  - ☐ Heredity disease
- ☐ Please explain in detail how the results of genetic test requested will impact the medical management of your patient.
- ☐ Include documentation of genetic counseling and/or specific plan for genetic counseling.

Please provide history and physical including onset of symptoms, lab tests, imaging, and treatment received, and response to treatment.

This is not an inclusive list. Additional information may be requested.

What do I do now?

Please fax this page and your completed Preauthorization Request Form to Health Services:
Fax: (541) 225-3625 Questions? Please call us toll-free at (888) 691-8209 or (541) 684-5584.

Where do I find the Preauthorization Request Form?

You'll find the Preauthorization Request Form at: PacificSource.com/provider/preauthorization.aspx