PREVENTION GENETICS

Test information is available on our website: www.PreventionGenetics.com

All testing must be ordered by a qualified Healthcare Provider

BENEFIT INVESTIGATION REQUEST

PreventionGenetics will file a benefit investigation and/or pre-authorization on behalf of the patient with any commercial insurance company and Wisconsin Medicaid. Initial benefit investigation is often completed within 24-48 hours. Benefits quoted will be based on our status as an out-of-network provider. We are in-network (contracted provider) with a limited number of health plans (see website).

Pre-authorizations can take some time to obtain depending on each individual insurance plan's policy and documentation requirements. If a specimen is received while pre-authorization is still in process, the DNA will be extracted and testing put on hold until the pre-authorization has been processed. Turnaround time for test results begins after the pre-authorization has been processed and approved.

If the patient's specimen is collected in the state of New York, a New York State Non-Permitted Laboratory Test Request approval letter (where applicable) and Genetic Testing Healthcare Provider Statement must be included at time of specimen submission.

To request assistance, please provide the following information to insurance@preventiongenetics.com or fax (715) 207-6602.

PATIENT INFORMATION

☐ SHARE RESULTS OF BENEFIT INVESTIGATION WITH PATIENT DIRECTLY VIA EMAIL OR FAX# _____

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH
			____ / ____ / ____ (MONTH / DAY / YEAR)

ADDRESS	CITY	STATE	ZIP

PATIENT ID CODE / MRN	PATIENT PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ☐ ATTACH COPY OF FRONT AND BACK OF PATIENT'S INSURANCE CARD ☐ ATTACH SECONDARY INSURANCE CARD

ADDRESS	CITY	STATE	ZIP

PHONE NUMBER	POLICY ID#	GROUP NUMBER / GROUP NAME

POLICY HOLDER NAME	POLICY HOLDER DATE OF BIRTH	RELATIONSHIP TO PATIENT

PreventionGenetics TEST INFORMATION

TEST CODE	TEST NAME

CPT CODE(S)	TEST PRICE	ICD-10 CODE(S)

ADDITIONAL REQUIREMENTS FOR PRE-AUTHORZATION / CLAIM FILING

☐ Relevant Medical Records addressing medical necessity and/or Letter of Medical Necessity

In some cases you may be asked to provide additional information to our billing staff in order to process pre-authorization with the insurance company.

REQUESTER / ORDERING PROVIDER INFORMATION

FACILITY NAME	DATE OF REQUEST
	____ / ____ / ____ (MONTH / DAY / YEAR)

ADDRESS	CITY	STATE	ZIP

CONTACT NAME	E-MAIL	PHONE

ORDERING PROVIDER	NPI #	FAX