Humana

Molecular Diagnostic/Genetic Testing Preauthorization Request Fax Form

Member/Provider Demographics:

Member Name: _____ Date of Birth: ___/___/_____

Humana Member ID Number: _____

Requesting Provider Information:

Name: _____ Phone Number: _____

Tax ID/NPI: _____ Fax Number: _____

Servicing Provider Information:

Name: _____ Phone Number: _____

Tax ID/NPI: _____

Test Requested:

Test Name: _____

Date of Service: _____ Diagnosis: _____

ICD Codes: _____

CPT Codes: _____

Test Ordered For: _____

Member History:

_____

_____

_____

_____

Humana.

Family History:

_____
_____
_____
_____

Other Findings/Testing Completed:

_____
_____
_____
_____

How Testing Will Be Used in Relation to Treatment:

_____
_____
_____
_____

[ ] Yes, I would like to have a peer-to-peer discussion with the Humana medical director if the request does not result in approval.

[ ] No, I do not want a peer-to-peer discussion.

Please also indicate the requesting physician's best availability and contact number:

[ ] Morning [ ] Lunch [ ] Afternoon Phone Number: _____

Please fax this form to the Genetic Guidance Program at 1-855-227-0677.