Independent Health Genetic Testing Authorization Request Form

IH Medical:	Phone: (716) 631-3425	Fax: (716) 635-3910
IH Behavioral Health:	Phone:(716) 631-3001 EXT 5380	Fax: (716) 635-3776

NOTE: all fields on this form must be completed. If not, delay of determination may result. Please be advised that Independent Health must have the necessary information to process the request timely.

REQUEST FOR: ☐ **IH MEDICAL Outpatient/ Procedure** **LAB DRAW DATE:**_____

☐ **IH BEHAVIORAL HEALTH Outpatient/ Procedure** **LAB PROCESSED/RUN DATE**_____

MEMBER INFORMATION

MEMBER ID: ☐☐☐☐☐☐☐☐☐ **SUFFIX:** ☐☐

NAME: _____ _____ DOB:_____ _____

Home/Cell Phone: (____) ____-_____ Address:_____

State: ____ Zip Code: _____

REQUESTING PHYSICIAN/PROVIDER INFORMATION:

NAME: **NPI:**☐☐☐☐☐☐☐☐☐☐

Office Contact Name: TAX ID:☐☐-☐☐☐☐☐☐☐

Address: _____ _____ City: _____ _____ State: ____ Zip Code: _____

Phone Number: (____) ____-_____ Ext: _____ Fax: (____) ____-_____

RENDERING LABORATORY INFORMATION:

NAME: **NPI:**☐☐☐☐☐☐☐☐☐☐

Office Contact Name: TAX ID:☐☐-☐☐☐☐☐☐☐

Address: _____ _____ City: _____ _____ State: ____ Zip Code: _____

Phone Number: (____) ____-_____ Ext: _____ Fax: (____) ____-_____

DIAGNOSIS CODES (ICD-10): 1_____ 2_____ 3_____

REQUESTED SERVICE(S): (ATTACH: copy of physician's order and/or Certificate of Medical Necessity **as well as all** relevant medical records i.e.; evaluations, imaging studies, labs, etc.)

Units / CPT codes	Item Description	

Would processing this request after seventy-two (72) hours, place the member's life, health or ability to regain maximum function in serious jeopardy? ☐ NO ☐ YES

4/2023

UnitedHealthcare® Options PPO Network

Independent Health®