USE THIS FORM TO REQUEST INSURANCE AUTHORIZATION PRIOR TO SPECIMEN COLLECTION. THIS IS NOT AN ORDER FOR TESTING.

» If submitting a specimen with a request for insurance authorization, do not continue with this form; instead, utilize the appropriate test request form and indicate that insurance authorization is needed.

» Please note, the ideal time to submit a patient specimen and orders for testing is after all steps below are completed.

To begin the insurance authorization process:

1. Complete attached form. The information requested is required by insurance carriers to determine eligibility of coverage for genetic testing.

2. Include a legible copy of the front and back of the patient’s insurance card AND relevant clinic notes.

3. Submit to our Client Services team by:
   • email (clientservhgl@unmc.edu) using the email button at the bottom of the form or
   • fax (402-559-7248)

What to expect after submitting a request:

4. An ‘Insurance Authorization Update’ will be sent in nearly all situations to the ordering provider (by the method designated in section D of the attached form.)

5. Testing automatically proceeds if the out of pocket estimate is $100 or less. Otherwise, we need verbal or written notice from the provider or patient to proceed.

6. The provider is responsible for coordinating specimen collection and shipment to our laboratory.
   • Though not required, test collection kits are available upon request by contacting our Client Services team by email (clientservhgl@unmc.edu) or phone (402-559-5070).
   • Access online forms to order testing: http://www.unmc.edu/mmi/geneticslab/ordering/laboratory-forms.html

▼ Continue to form
### A. PATIENT INFORMATION

- **Date Requested:**
- **Name:**
- **DOB:**
- **Biological Sex:**
- **MR#:**
- **Phone #:**
- **Address:**
- **City/State/Zip:**

- **Patient demographics provided in Nebraska Medicine EPIC**

### B. INSURANCE INFORMATION

**Insurance Card Required to start authorization**
- **Insurance card provided** (clear, enlarged copy of card - front and back)
- **Policy Holder is different than the patient**
  - **Policy Holder Name:**
  - **Policy Holder DOB:**
- **Insurance card provided in Nebraska Medicine EPIC**

### C. CLINICAL INFORMATION

**Clinical Records Required to start authorization**
- **Records attached** (family history, pedigree, previous genetic testing reports)
- **Clinical records provided in NE Med EPIC - clinic date:**

**Specimen Type to Be Drawn**
- **Amniotic Fluid**
- **Chorionic Villi (CVS)**
- **POC/Fetal Tissue**
- **Blood/Cancer Blood**
- **Extracted DNA**
- **Solid Tumor**
- **Bone Marrow or Core**
- **Lymphatic Tissue/Node**
- **Tissue/Skin**
- **Buccal Mucosa Swab**
- **Paraffin Embedded Tissue**
- **Urine/Bladder Washings**

**Indications for Testing or ICD:**

### D. PROVIDER INFORMATION

- **Name:**
- **Facility:**
- **Address:**
- **City/State/Zip:**
- **Phone:**

**Authorization determination will be communicated to you based on your selected preferences below.**
- **EMAIL me:**
- **FAX me:**
- **Send additional email/fax to:**

**Notes:**

### E. TESTING TO BE AUTHORIZED

**This is NOT an order for testing**
- **Chromosome Analysis**
- **Chromosome Breakage** for Fanconi anemia
- **FISH** [specify]:
- **Fragile X** [performed & reported by Nebraska Medicine Molecular Diagnostic Lab]
- **Male Infertility PANEL** [includes Chromosome Analysis and YCMD]
- **Methylation Analysis - Chrom 14** [Temple synd (Prader-Willi-like), Pat UPD 14]
- **Methylation Analysis - Chrom 15** [Prader-Willi synd, Angelman synd]
- **Y Chromosome Microdeletion (for male infertility)**

**Microarray Analysis**
- Cancer
- High Density SNP
- Pregnancy Loss
- Prenatal

### F. SUBMIT FORM

**EMAIL:** clientservhgl@unmc.edu  **OR**  **FAX:** 402-559-7248

11-7-2019