SAS
SOLUCIONES ANALITICAS DE SALUD

Metro Office Park, Millennium Park Plaza 15, Street 2, Ste 540, Guaynabo, PR 00968
Phone: 877-815-0819 • Fax: 844-964-7707
www.oncohealth.us

Genetic or Molecular Testing Prior Authorization Request Form

REQUEST DATE: _____ **TREATMENT START DATE: _____**

PLEASE SUBMIT PROGRESS NOTES, PATHOLOGY REPORT, AND TEST REQUISITION WITH REQUEST

☐ **Standard**

☐ **Urgent** - Mark as **Urgent**, if the request meets one of the definition/level of service listed below

- ☐ Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; or
- ☐ Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological function; or
- ☐ In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- ☐ Based on this definition, I hereby submit this authorization as an urgent request

I. MEMBER INFORMATION

First:	Last:	DOB:	☐ Male ☐ Female
Diagnosis:	ICD-10:	Stage (0-4):	
Insurance:	Line of Business (e.g., Medicare):	Member ID:	

II. GENETIC OR MOLECULAR TESTING CODES

ICD Diagnosis Code(s)	Description	CPT Code(s)	Requested Units per Code
Additional Information: Please provide panel code(s) if necessary.			

III. PROVIDER AND PLACE OF TREATMENT INFORMATION

Ordering Provider:	NPI #:	TIN #:	
	Phone:	Fax:	
Address:	City:	State:	Zip:
Provider: (if different; or provide lab name)	NPI #:	TIN #:	
Office Contact:	Phone:	Fax:	
Is this the only available servicing provider within a reasonable distance that can provide this service for the patient?		☐ Yes ☐ No ☐ Unknown	
Does this patient have a referral from the Health Plan to see this servicing provider?		☐ Yes ☐ No ☐ Unknown	
Is the servicing provider in-network?		☐ Yes ☐ No ☐ Unknown	

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