Network Health Plan/Network Health Insurance Corporation Genetic Testing Authorization Request Form

Fax Request to Care Management Department at 920-720-1903
Care Management Department Telephone: 920-720-1600

***Form Completed by:**
***Date Form Completed:**

MEMBER INFORMATION	ORDERING PROVIDER INFORMATION	RENDERING PROVIDER INFORMATION
*Member/Patient Name:	*Ordering Provider:	*Rendering provider or facility:
*DOB:	Phone #:	Phone #: Fax #:
Member ID#:	*Fax #:	Billing provider: (If different than rendering)

********Please include any clinical notes or office notes that would support request********

*Planned Date of Service	*CPT or HCPCS Code	*Service Description – (Name of test requested)	*Diagnosis/Purpose of Test	*How will the genetic test results change/impact future medical management of the member?

***Required Fields**

If you have questions about benefits, please call Customer Service at 1-800-826-0940 or 920-720-1300 for NHP Commercial members and 1-800-378-5234 or (920) 720-1345 for Medicare Advantage members.

NHP Only Authorization #: # Units Approved

Care Management Coordinator: ________________ Date Received: ____________ Start Date: End Date