

Statement of Medical Necessity for Genetic Testing

This form is to be completed by the attending/referring physician in recommendation of genetic testing.

Patient: _____

Patient Date of Birth: _____

Insured SSN or Patient ID#: _____

1). Describe the medical condition or symptoms; or *indicate ICD9 codes*:

2). Indicate the recommended genetic test laboratory analysis (*Test Code and Test Name*):

3). Briefly describe how the recommended analysis will improve the medical management of the patient's condition by providing a definitive diagnosis:

Signature of Attending Physician: _____

Print Physician Name: _____

NPI: _____

Date: _____

Address: _____

Phone: _____