Allegiance℠
by Cigna Healthcare

GENETIC TESTING PRE-TREATMENT REQUEST

Please return below form and clinicals to Attn: Utilization Management

Fax: (855) 999-3896

Phone: (800) 877-1122

Mail: Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

Sent By: Requested Date: Scheduled Date:

Patient Name:	Participant ID#:	Group ID No.:	Patient Date of Birth:
Ordering Provider Name:	Ordering Provider Address:	Ordering Provider TIN & NPI:	Ordering Provider Phone: Ordering Provider Fax:
Rendering Laboratory Name:	Laboratory Address:	Laboratory TIN & NPI:	Lab Phone: Lab Fax:
Diagnosis Codes (list ICD-10 codes here):			

Requested test name(s):	**CPT Codes**

*Requests that include unlisted procedure code(s) will require additional documentation supporting the use of that code(s). If documentation is not submitted supporting the requested unlisted code(s) your request may be delayed and/or denied. Unlisted codes will not be considered eligible if accurate and listed codes are available to describe the requested service or procedure.

Please provide the following information:

1. Clinical Geneticist, genetic counselor, advanced genetics nurse (AGN-BC), genetic clinical nurse (GCN), or advanced practice nurse in genetics (APNG) information (if different than providers above)
2. Three generation pedigree
3. Copy of the ordering health care provider's laboratory requisition form
4. Copy of genetics evaluation documentation

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Recommendation (Choose one of the following):

	This individual meets Cigna's Medical Coverage Policy criteria, and I support the testing Requested.
	This individual does not meet Cigna's Medical Coverage Policy criteria, but I support the testing requested for the reason(s) listed below (indicate alternative best practice guidelines that support your recommendation).
	I do not support the recommendation, but do recommend consideration of the following alternative testing (provide explanation below).
	This individual does not meet Cigna's Medical Coverage Policy criteria for the testing requested, and I recommend no genetic testing be performed at this time.
	I have no recommendation to make regarding the testing requested for the reason(s) described below.
	Reasons or explanation:

	By checking this box, I affirm that I am a genetic clinical nurse (GCN), advanced practice nurse in genetics (APNG), board-certified genetic counselor, a board-eligible/board-certified clinical geneticist, or have been specifically credentialed by Cigna to perform genetic counseling, and I am not currently employed by a genetic testing laboratory.
	By checking this box, I confirm I have attached a three-generation pedigree, copy of the ordering health care provider's lab requisition form, and a copy of my genetics evaluation documentation. I understand authorization may be denied if all documentation is not received.
	By checking this box, I confirm that I am a breast surgeon and that pre-testing genetic counseling is not being completed due to the urgent need to make a timely surgical decision. I further acknowledge that all other Cigna precertification requirements apply to services performed and that post-genetic testing genetic counseling will be obtained with an appropriately credentialed independent genetic counselor.

Signature

Signature:	Date:

Upon receipt of all required information, the Plan will provide a written response to the written request for pre-treatment. Please allow 3 business days for a response.

The benefits available are conditional on the participant's employment status, plan eligibility, payment of premiums, amount of benefits remaining, plan provisions and plan exclusions. If information obtained at the time of the claim places the service(s) in an excluded category or definition, the claim will not be payable. The benefits quoted are not guaranteed. Final determination of benefits to be paid will be made at the time a claim is submitted for payment, with review of the necessary medical records and other information.