Maryland
DEPARTMENT OF HEALTH

PREAUTHORIZATION REQUEST FORM

LABORATORY SERVICES

Participant Information

Name:	Date of Birth:
Medicaid Number:	Sex:

Ordering Provider Information

Name:		MA Provider Number:
Street Address:		Telephone:
City, State, Zip:		Fax:
Contact information for person completing this form:		
Name:	Email:	Phone:

Genetic Counselor Information – **FOR GENETIC TESTING REQUESTS**

Name:		MA Provider Number:
Street Address:		Telephone:
City, State, Zip:		Fax:
Contact information for person completing this form:		
Name:	Email:	Phone:

Testing Laboratory Information

Name:		MA Provider Number:
Street Adress:		Telephone:
City, State, Zip:		Fax:
Laboratory Contact Person:		
Name:	Email:	Phone:

PREAUTHORIZATION REQUEST FORM

LABORATORY SERVICES

Preauthorization Information

Requested Test Name:	CPT/HCPCS code(s):
Diagnosis:	ICD-10 code(s):

Preauthorization Line Item Information

CPT code	Mod 1	Mod 2	Requested Units	Department Use Only

Required Clinical Information for all Laboratory Requests:

Please attach documentation which includes but is not limited to the following:

- Complete narrative justification for procedure(s)
- Clinical note (including history and physical examination) from ordering provider
- Result of pertinent ancillary studies if applicable
- Pertinent medical evaluations and consultations if applicable

For Genetic Testing, please provide the following information:

Describe the laboratory and/or clinical testing that has been performed to date:

Describe why genetic testing is necessary at this time:

Describe how the results of the genetic test, whether negative or positive, will impact the future management of the participant being tested. Specifically, it will: (check all that apply)

☐ Inform on prognosis:
Explain:

☐ Change treatment plan (ie, medical or surgical decision-making or treatment):
Explain:

☐ Change surveillance (e.g., begin or stop annual echocardiograms)
Explain:

☐ Prevent the need for further diagnostic testing:
Explain:

☐ Provide information for family members:
Explain:

What is the probability that this test will be positive?
If this is not known, then please indicate which clinical features increase the probability that this test will provide a diagnosis.

If this is a request for a gene panel, please describe why a single gene test is not as useful:

If the genetic test is for an inherited condition, please describe how the participant is at risk of inheriting the genetic mutation and attach a three-generation pedigree:

Preauthorization Number (Department Use Only)

Submission Instructions:
Fax completed form and all requested attachments to:
1-410-767-6034