Maryland
DEPARTMENT OF HEALTH

PREAUTHORIZATION REQUEST FORM

LABORATORY SERVICES

Participant Information

Name:	Date of Birth:

Ordering Provider Information

Name:	MA Provider Number:

Genetic Counselor Information

Name:	MA Provider Number:
Street Address:	Telephone:
City, State, Zip:	Fax:

Contact Information – Person completing this form:

Name:	Email:	Telephone:

Testing Laboratory Information (must be a Children's Medical Services participating provider)

Name:	MA Provider Number:
Street Address:	Telephone:
City, State, Zip:	Fax:

Preauthorization Information

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

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

- Clinical note (including history and physical examination) from ordering provider.
- Pertinent medical evaluations and consultations, if applicable.

Please provide the following information:

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

Describe why genetic testing is necessary currently:

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 (ie., 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 the participant is a risk of inheriting the genetic mutation and attach a three-generation pedigree:

Submission Instructions:
Email completed forms and all requested attachments to:
mdh.childrensmedicalservices@maryland.gov

Submissions can also be faxed to 443-275-5434