GENETIC TESTING SERVICE AUTHORIZATION REQUEST

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 527 (5-2018)

Clear Fields

The following provider information is required to complete the service authorization request:

Procedure Request

Billing Provider Name and NPI - name of the clinic, group, or sole proprietor and associated NPI that will be listed in Box 33 (a) and (b) of the CMS 1500 or electronic equivalent (not the individual rendering provider).

Billing Facility Name and NPI - name of the facility (hospital or ambulatory surgery center) and associated NPI that will be billing for the technical or facility portion of the surgical procedure (where the surgery will be performed).

Modifiers

CPT and HCPCS codes must be requested exactly how they will appear on the claim. All applicable modifiers must be present on the service authorization request. Failure to do so will result in a denial of the claim.

RECIPIENT INFORMATION

Recipient Last Name, First Name, Middle Initial	Recipient Medicaid ID Number	Date of Birth

ICD-10 CM CODES (required)

1)	2)	3)	4)	5)	6)
7)	8)	9)	10)	11)	12)

PROVIDER INFORMATION

Billing Provider Name (see instructions)	Billing Provider NPI	Requested Date of Procedure
Billing Facility Name		Billing Facility NPI

REQUESTING PROVIDER CONTACT

Contact Person Name	Telephone Number	Fax Number	Today's Date

REQUESTED TESTS - all applicable modifiers used for billing must be present on the Service Authorization Request

CPT / HCPCS Code and Applicable Modifiers		1) Code	Mod	2) Code	Mod	3) Code	Mod	4) Code	Mod
5) Code	Mod	6) Code	Mod	7) Code	Mod	8) Code	Mod	9) Code	Mod

**Pharmacogenetic panel tests for therapy selection, such as panel tests for psychotropic, analgesics or ADHD stimulant medications are considered not medically necessary and therefore not covered.

WHAT THERAPIES AND MEDICATIONS ARE CURRENTLY IN PLACE? (Please attach results of all diagnostic testing. For example, labs, biopsy, pathology, x-rays, results of previous genetic testing performed, if any).

How will the outcome of the genetic testing affect the recipient's plan of care if the results are positive or negative? (Please be specific, for example: List medications that will be added or discontinued, specific therapy or procedures needed that will be associated with positive or negative results, or further screening or diagnostic testing that would be needed and has not already been evaluated) .

BRCA SPECIFIC QUESTIONNAIRE - please mark all that apply

- ☐ Patient is identified as high-risk for BRCA mutation and is age 19 or older. High-risk includes the following factors:
  - ☐ Woman of Ashkenazi Jewish descent (or other ethnicity/population for which founder mutations in the BRCA gene have been identified) with any first degree relative or two second relatives on the same side of the family with breast or ovarian cancer.
  - ☐ Woman or other ethnicity who has one or more of the following factors:
    - ☐ First or second degree relative with breast cancer and at least one of the following:
      - ☐ diagnosed at age 45 or younger
      - ☐ diagnosed at age 50 or younger and limited or unknown family history or with one additional first or second degree relative diagnosed with breast cancer at any age
      - ☐ diagnosed at age 60 or younger with triple-negative breast cancer
    - ☐ First of second degree relative with 2 breast primaries and the first primary diagnosed at age 50 or younger.
    - ☐ First or second degree relative with breast cancer diagnosed at any age and 1 or more of the following:
      - ☐ One additional first or second degree relative with breast cancer diagnosed at age 50 years or younger
      - ☐ Two or more first or second degree relatives on the same side of the family with epithelial ovarian cancer
      - ☐ Three or more first or second degree relative on the same side of the family with breast cancer diagnosed at any age
      - ☐ First of second degree relative with both breast and epithelial ovarian cancer
- ☐ Patient has a personal history of breast cancer:
  - ☐ diagnosed before age 60 and triple-negative
  - ☐ diagnosed before age 45
  - ☐ diagnosed at any age with a first or second degree relative with breast cancer diagnosed before age 50
- ☐ Patient has a personal history of epithelial ovarian cancer.

☐ I certify that the information given in this form is a true and accurate medical indication for the procedure(s) required.

Provider Signature	Date

REMARKS (state use only)

☐ Approve	Start Date	End Date	Clinical SA Number	Facility SA Number
☐ Deny	Reason			
☐ Pending	Reason			
Comments				
Signature of Reviewer				

Prior authorization does not guarantee payment for the services; payment is contingent upon passing all edits contained within the claims payment process, the recipients continued Medicaid eligibility, the providers's continued Medicaid eligibility, and ongoing medical necessity for the services.

Send to: Medical Services Division
ND Department of Human Services
600 E Boulevard Ave, Dept. 325
Bismarck, ND 58505
Fax: (701) 328-1544