Prior Authorization Form

Please Fax To (952)853-8713 For Questions Call (952)883-6333

HealthPartners

Hereditary Breast and Ovarian Cancer Genetic testing Medical Review Form
BRCA 1 & BRCA 2 genes
BRAC*Analysis* Rearrangement Test (Reflex to BART)

Patient information		
Patient Name:	HealthPartners ID #:	
DOB:		
Requester information		
Form Completed By:	Clinic/Facility:	
Fax # for reply:	Phone #:	
Physician information		
Physician name:	Clinic/Facility:	
Tax ID #:	Phone #:	Fax #:
Billing Lab information		
Lab Name:	Fax #:	
Tax ID #:	Phone #:	
Procedure information		
Proposed date of procedure: / / or ☐ TBD		
ICD 9 code:	Diagnosis:	

All requests for hereditary breast/ovarian cancer genetic testing must meet NCCN Guidelines.
Please check all that apply:

☐ **Comprehensive BRAC*Analysis* test** (CPT code 81211)
☐ **BRAC Analysis Rearrangement Test (REFLEX to BART)** in the event that the Comprehensive BRAC*Analysis* is negative (CPT code 81213)

☐ **Multisite 3 BRAC*Analysis* test** (CPT code 81212, individual is of Ashkenazi Jewish ancestry)

Single Site BRAC*Analysis* test:
☐ **BRCA1** (CPT code 81214 or 81215)
☐ **BRCA2** (CPT code 81216 or 81217)
☐ **Other (please specify):**____

Patient Counseling(must be completed prior to request)	
Name of genetic counselor or medical geneticist:	
Clinic/Facility:	Fax#:
Phone#:	Date of counseling:
Summary notes included with request ☐ yes ☐ no	

Required supportive documentation must include:
Summary notes from a board certified genetic counselor or medical geneticist, (not affiliated with the testing lab) must indicate a recommendation for BRCA and/or BART genetic testing, per NCCN Guidelines.

Updated 7/1/2013