Insurance Preauthorization Information from the Division of Medical Genetics, University of Utah Medical Center, June 2008

The medical geneticist who evaluated you or your child at XXXX recommended testing at today's visit. It is your responsibility as the patient to confirm whether or not your insurance company covers the recommended testing. Preauthorization may be required. Please understand that any insurance coverage is a contract between you and your insurance carrier. We recommend that you contact your insurance company prior to obtaining laboratory studies or radiographic studies. The Division of Medical Genetics is not liable for the costs associated with testing.

You will need your insurance card and the following information at the time of your phone call to your insurance company.

Insurance Company _____
Patient Name _____Date of birth_____
Subscriber _____
ID # _____Group name or # _____

Physician requesting test _____
Blood will be drawn at _____ hospital
Diagnosis _____

Tell your insurance company that you are requesting pre-authorization for the following tests that are DIAGNOSTIC and MEDICALLY INDICATED:

_ Chromosome study (karyotype) –CPT codes 88262, 88230, 88280, 88291
_ High resolution chromosome study – CPT codes 88262, 88230, 88289, 88291
_ Family chromosome study – CPT codes 88230, 88261x 2, 88291
_ FISH for _____(metaphase) – CPT codes 88271, 88273, 88291
_ CGH microarray-constitutional chip – CPT codes 88386, 88385, 83890
_ CGH microarray-1 Mb chip – CPT codes 88386 x 5, 88385, 83890
_ CGH microarray-combo chip – CPT codes 88386 x 6, 88385, 83890
_ Fragile X – CPT codes 83890, 83892, 83894, 83898, 83912
_ Methylation for _____ - CPT codes 83890, 83898, 83912
_ Other testing _____
_ DNA for _____ CPT codes _____
_____to be sent to_____

Document the following information about your insurance company encounter:
Date of phone call _____
Name of person you spoke with at your insurance company _____
Phone number with extension _____
Preauthorization number _____Dates valid_____

****If validation is denied or further documentation is needed, write down the Case number _____ Fax number _____
Ask if a letter of medical necessity is needed? __Yes __No
Request that the insurance company FAX an appeals form to (801)585-7252
If you need a lab order after obtaining preauthorization, call (801)581-8943, option 2

If you need additional action by the Division of Medical Genetics, return this form before leaving clinic or FAX to (801) 585-7252

Keep a copy of this paper with your other medical records and important documents.