of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

Genetic Testing Request Form

Please complete one form for each request. To request services for Commercial fax to 1-866-558-0789.
Requests can be submitted online at any time through **Availity.com**.
A completed form is required in Availity and via fax.
The form can be added as an attachment with the online submission.

Date Submitted:_____ Pages attached (include cover and/or form):_____

Contact Name:_____ Contact Phone #:_____ Contact Fax #:_____

***** Please be sure contact fax number is clear due to HIPAA, since decision letters will be faxed to the provider.***

Member Name:	Member ID Number:
Date of Birth (mm/dd/yy):	☐ Male ☐ Female
Diagnosis (including ICD-10-CM Code):	

Requesting provider information below:

Requesting Provider:	Provider #:	NPI #:
Telephone #:	Fax #:	
Address:		
City:	State:	ZIP:

Facility/Lab:	Facility/Lab Provider #:	Facility/Lab NPI #:
Facility/Lab Telephone #:	Facility/Lab Fax #:	
Facility/Lab Address:		
City:	State:	ZIP:

Blood/Tissue collection date: _____

Date of service requested: From _____ **to** _____

Indications / Purpose of the requested test(s): _____

Codes continue on next page

Member Name:_____Date of Birth:_____Subscriber ID:_____

Requested test(s) information: Only one test request per line. CPT/HCPCS codes should be specific to that test and not unbundled. Must be the most appropriate code for that test.

Requested Test Name(s)	CPT/HCPCS Codes(s)	Panel Test (yes or no)

Medical records needed for review. Please submit the following from the ordering/treating provider:

- Specimen collection date (if applicable)
- Test name or type
- CPT/HCPCS codes (correct – unbundled codes)
- ICD code relevant to the requested tests
- Indication (reason) for the test
- Relevant past test history
- Medical history relevant to the need for the test
- Known familial history relevant to the need for the test (include age of onset if known)
- Known familial mutation/specific mutation.
- Use of results in patient care
- Pertinent labs, plan of care that supports relevancy of the test toward the treatment plan
- Pertinent clinical documentation that supports the test requested
- Relevant further testing if negative.

By submitting this request, you are confirming that you have provided all clinical information available pertinent to this request and you are requesting the decision be made based on information provided in your submission.