INSURANCE VERIFICATION OF COVERAGE for GENETIC TESTING

NAME INSURANCE COMPANY

SUBSCRIBER NAME

DATE OF BIRTH

POLICY NUMBER

Date:

Dear Claims Specialist,

This is a request for verification of insurance coverage and pre-authorization on behalf of patient PATIENT NAME for genetic testing and includes a description of the medical necessity for testing. Genetic testing for [LIST GENES AND/OR DISORDER] has been ordered by the patient's physician to be completed by the **Center for Precision Diagnostics,** a CLIA certified laboratory at the University of Washington Department of Pathology (CAP: 24637-08, CLIA#: 50D0661462).

Justification of Test Choice:

The purpose of genetic testing is to identify the underlying molecular basis of a genetic disorder in this patient in whom we have been unable to identify a disease cause by conventional medical testing. Indications for testing include [LIST CLINICAL INDICATIONS]. **Results of genetic testing will allow the physicians who care for the patient to learn the mechanism of the identified disease and will guide them in making recommendations for medical care of their patient.** If a gene mutation is confirmed, it will also assess the risk for the subscriber's family members who may have the same condition.

Benefit of genetic testing to the Patient:

An accurate diagnosis provides the following benefits to the patient.

- Eliminates expensive repeated evaluations by various specialists
- Eliminates the need for further expensive and invasive diagnostic testing
- Allows accurate counseling regarding recurrence risk, prognosis, involvement with other organs and treatment

Thank you for your review and determination of the test request. I hope you will support this request for genetic testing coverage for [PATIENT_FIRST_NAME] [PATIENT_LAST_NAME]. If you have questions please feel free to call contact me at [PHYSICIAN_PHONE_NUMBER].

Sincerely,

PHYSICIAN

Cc: SUBSCRIBER/PATIENT