



Horizon Blue Cross Blue Shield of New Jersey

Date of Request: _____

In place of this Form you can submit Authorization Requests Online securely via Navinet. If you are not registered, please visit Navinet.net and click Sign Up or call Navinet Customer Care at 1-888-482-8057.

Genetic Testing Authorization Request Form

Requirements: *Clinical information and supportive documentation should consist of office visit notes and recent diagnostics. Test results must be submitted to support request for approval. . Notification required for any date of service change. Please complete this form in its entirety, in order to prevent processing delays.*

Fax completed form to: Horizon NJ TotalCare (HMO SNP) at 1-609-583-3013

General Information

Member Name: _____ Member ID #: _____ DOB: _____

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

List Any Additional Insurance: _____

Policy Name/Number: _____

Medical Information Needed

Date/Date Range of Service: _____

Days/Units Requested: _____

Primary Diagnosis: _____ Other Chronic Diagnosis: _____

ICD 10 Codes: _____

Procedures(s) Requested: _____

CPT Codes Requested: _____

Servicing Facility: _____ ID# & NPI#: _____ TIN#: _____

Location of Service: Outpatient Hospital Hospital SPU/OR Other

Additional Required Information

Name of disease for which testing is requested: _____

Specific reason for testing in this disease and this patient: _____

Member is suspected of being: () Affected () Carrier

Benefit/reason for testing:

- Confirmation of diagnosis for prenatal diagnosis
- Confirmation of diagnosis to change clinical management
- Confirmation of diagnosis to inform testing of relative

Additional information relevant to the request: _____

Has it been verified that a participating Horizon NJ TotalCare (HMO SNP) laboratory does not offer this testing? Yes No