DIAGNOSTIC CYTOGENETICS INCORPORATED
1525 13th Ave. Seattle, WA 98122
800-328-2026 fax 206-325-2975
www.diagnosticcytogenetics.com

REQUEST FOR PRE-AUTHORIZATION FOR CYTOGENETIC TESTING FOR

CONSTITUTIONAL SAMPLES

To be completed and FAXED or CALLED to the insurance carrier.

PATIENT, INSURANCE, and REFERRING PHYSICIAN INFORMATION:

Patient Name:_____ Date of Birth: _____
Insurance Provider:_____ Phone:_____
Policy ID #:_____ Fax:_____
Policy Holder Name:_____ Date of Birth:_____

This patient is currently being cared for by the following physician, who recommends cytogenetic testing on amniotic fluid/products of conception/solid tissue/peripheral blood specimen(s) be performed by Diagnostic Cytogenetics Inc. [Tax ID: 91-1134800 / NPI: 1104899376].

Referring Physician:_____ Ref Phys's NPI:_____
Facility & Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

NECESSARY TEST(S) REQUESTED and CPT CODES:

☐ **Chromosome Analysis: amniotic fluid**: 88235, 88267 or 88269, 88280, 88285, 88291
☐ **Chromosome Analysis: products of conception/solid tissue**: 88233, 88262, 88280, 88291
☐ **Chromosome Analysis: peripheral blood**: 88230, 88262, 88280, 88289, 88291
☐ **FISH: all tissue types:** 88283, 88377

Some codes may be charged in multiple units, depending on patient-specific testing parameters.

Date of Service: _____
Indication(s) for Testing:_____
ICD-9 Code(s):_____

How will approving this request change the course of treatment?
Goal of treatment?
What is the clinical justification for this request (if not addressed above)?

Submission of clinical chart notes is required to evaluate the medical necessity of request.

Making a diagnosis is essential for this patient's current medical management and ongoing healthcare.

*Signed:*_____ *Date:*_____
*Printed Name:*_____

PLEASE FORWARD PRE-AUTHORIZATION TO:

☑ Referring Physicians listed above
☑ Diagnostic Cytogenetics Inc
Fax 206-325-2975 / Phone 800-328-2026