PRE-SERVICE/
PRIOR AUTHORIZATION
REVIEW REQUEST

Fax to Care Management:
800-843-1114

LifeWise

Request Date _____ .

☐ **URGENT** – All requests to LifeWise Health Plan of Oregon marked as urgent/expedited must include supporting documentation from the physician's office that the application of standard timeframes for making a non-urgent determination: (a) could seriously jeopardize the life or health of the patient or the ability to regain maximum function, or, (b) in the opinion of a physician with knowledge of the member's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment being requested.

MEMBER/PATIENT _____ Date of Birth _____
Member ID _____ Suffix _____ Group # _____

REQUESTING PROVIDER _____	**SERVICING PROVIDER** Diagnostic Cytogenetics, Inc.
Address _____	Address 1525 13th Ave
City/State/ZIP _____	City/State/ZIP Seattle, WA 98122
Phone _____ Fax _____	Phone 800-328-2026 Fax 206-325-2975
Optional information below *– please include if known.*	***Optional information below*** *– please include if known.*
Contact Person _____	Contact Person Michele Bailey
Tax ID/NPI # _____	Tax ID/NPI # Tax ID: 91-1134800 / NPI: 1104899376
Contracted Provider: ☐ Yes ☐ No	Contracted Provider: ☐ Yes ☐ No

Procedure/CPT	Diagnosis ICD-9
In situ hybridization, multiplex probe staining, morphometric, manual / 88377	

CLINICAL INFORMATION – Attach supporting medical records and include presenting symptoms and previous treatment.

☐ Outpatient ☐ Inpatient Facility Name _____
Date Scheduled _____ ☐ Initial Treatment ☐ Concurrent/Ongoing Treatment ☐ Post-Service*
Existing Reference # _____ **Expiration Date** _____

*If submission of this form is more than seven days post-service, medical necessity will be reviewed upon submission of the claim.

Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.