BAYLOR
GENETICS

BAYLOR GENETICS
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GRAND BLVD. RECEIVING DOCK
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CONNECT

STATEMENT OF MEDICAL NECESSITY FOR GENETIC TESTING

THIS FORM IS TO BE COMPLETED BY THE ATTENDING/REFERRING PHYSICIAN IN RECOMMENDATION OF GENETIC TESTING

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY)

Insured SSN or Patient ID #

Describe the medical condition or symptoms; or indicate ICD9 codes:

Indicate the recommended genetic test laboratory analysis (Test Code and Test Name):

Briefly describe how the recommended analysis will improve the medical management of the patient's condition by providing a definitive diagnosis:

Attending Physician Signature | Physician Name | NPI | Date (MM / DD / YYYY)

Address | City | State | Zip | Phone