



STATEMENT OF MEDICAL NECESSITY FOR GENETIC TESTING

This form is to be completed by the attending or referring physician to support the recommendation for genetic testing.

PATIENT INFORMATION

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

Patient Insurance ID Number _____

CLINICAL INFORMATION FOR TEST JUSTIFICATION

Describe the patient's medical condition or symptoms, or indicate ICD-10 codes:

Indicate the recommended genetic test(s) and laboratory analysis (i.e., test name[s]):

Briefly describe how the recommended analysis will support medical management of the patient's condition, including how it may contribute to a definitive diagnosis:

If Baylor Genetics is not in network with the patient's insurance carrier, please provide justification for requesting testing with an out-of-network lab:

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

Address _____ City _____ State _____ Zip _____ Phone _____