Prior Authorization Request Form

The University of Chicago Genetic Services Laboratories
5841 South Maryland Avenue, Room G701/MC0077, Chicago, IL 60637
Toll Free: 888.824.3637 | Local: 773.834.0555 | Fax: 773.702.9130
youtlaw@bsd.uchicago.edu | dnatesting.uchicago.edu | CLIA#: 14D0917593 | CAP#: 18827-49

We currently only offer institutional billing and self-pay for our exome sequencing tests. Insurance prior authorization is not absolutely mandatory before sending a sample to our laboratory. Insurance prior authorization services are offered as a courtesy and can be requested PRIOR to sending a sample to our laboratory. Samples received with appropriate billing information (institutional billing or self-pay) will be processed accordingly

Patient Information

Name: *Last* _____ *First* _____ *(MI)* _____

Date of Birth: ____/____/____ University of Chicago MRN (*if applicable*): _____

Gender: ☐ Male ☐ Female Service Start Date: ____/____/____ Service End Date: ____/____/____

Test Name: _____ Test (CPT) code: _____

Test Name: _____ Test (CPT) code: _____

Test Name: _____ Test (CPT) code : _____

Provider Information

Requesting Provider Name: _____ ☐ MD ☐ DO

Requesting Provider NPI#: _____ Phone: _____ Fax: _____

Contact Person: _____ Title: _____

Email: _____ Phone: _____ Fax: _____

Servicing Provider/Facility Name: Darrel Waggoner, M.D. / University of Chicago Genetic Services Laboratories

Servicing Provider NPI# : 1669595872 Tax ID: 36-2177139 Phone: 773-834-8220 Fax: 773-834-0556

Member Information (*We do NOT accept Illinois or any out-of-state Medicaid.)*

Please provide a legible photocopy of the front and back of the patient's insurance card.

ICD-9/ ICD-10 Diagnosis Code(s): _____ Description: _____

Subscriber Name: _____ Date of Birth: ___/___/_____ Gender: ☐ Male ☐ Female

Subscriber Address: _____ City: _____ State: _____ Zip: _____

Subscriber Relationship to the Patient: ☐ Self ☐ Spouse/Partner ☐ Child ☐ Other _____

Health Plan/ Insurance Name : _____ Policy No. _____ Group No.: _____

Health Plan/Insurance Phone: _____ Health Plan/Insurance Fax: _____

The policy holder's signature to the following statement: I hereby authorize any physician who treated or attended to me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I hereby transfer and assign to the University of Chicago Genetic Services Laboratories any benefits of insurance I may have. I assume responsibility for the balance of the cost of testing not paid by my insurance company. A photocopy of this authorization shall be considered as effective and valid as original.

Authorized Signature: _____ Date: _____/_____/_____

UCGSL Prior Authorization Results (*Do not write in this area*)

: ☐ Approved ☐ Denied : ☐ Other _____ Reference # _____

Begin Date: ____/____/_____ End Date: ____/_____/_____ # Visits: _____ Prior Authorization # _____

Comments: _____

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