

## PED-I-CARE GENETIC TEST REQUEST SUPPLEMENTAL INFORMATION

Please complete this form and submit along with the Ped-I-Care Medical Authorization Request Form, CMS Special Exemption Form, and supporting clinical documentation. This information will be reviewed by the Medical Director.

Member: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

### Requested Test:

Test description (including documentation):

Specificity of test:

Sensitivity of test:

Laboratory:

Laboratory Phone #:

Address:

### Major clinical features:

### Previous pertinent lab studies/diagnostic investigations:

### Level of actionable consequences of testing (please answer all that are applicable):

Genetic Counseling for future children in family:

Medical monitoring changes:

Treatment considerations:

Life altering changes: