PREVENTION GENETICS part of EXACT SCIENCES

Test information and additional requirements are available on our website:
**PreventionGenetics.com**

All testing must be ordered by a qualified Healthcare Provider

# BENEFIT INVESTIGATION REQUEST

PreventionGenetics will file a benefit investigation and/or pre-authorization on behalf of the patient with any commercial insurance company and Wisconsin Medicaid. Initial benefit investigation is often completed within 24-48 hours. Benefits quoted will be based on our status as an out-of-network provider. We are in-network (contracted provider) with a limited number of health plans (see website).

Pre-authorizations can take some time to obtain depending on each individual insurance plan's policy and documentation requirements. If a specimen is received while pre-authorization is still in process, the DNA will be extracted and testing put on hold until the pre-authorization has been processed. Turnaround time for test results begins after the pre-authorization has been processed and approved.

***To request assistance, please provide the following information to support@preventiongenetics.com or fax (715) 207-6602.***

## PATIENT INFORMATION

| LAST (FAMILY) NAME | FIRST NAME | MI | DATE OF BIRTH (MM/DD/YYYY) |
|---|---|---|---|
| | | | |

| ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| PATIENT EMAIL ADDRESS *(Required for Quote of Benefits to be sent to the patient)* | PATIENT PHONE NUMBER |
|---|---|
| | |

## INSURANCE INFORMATION

**PRIMARY INSURANCE COMPANY** ☐ ATTACH COPY OF FRONT AND BACK OF PATIENT'S INSURANCE CARD ☐ ATTACH SECONDARY INSURANCE CARD

| ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| PHONE NUMBER | POLICY ID# | GROUP NUMBER / GROUP NAME |
|---|---|---|
| | | |

| POLICY HOLDER NAME | POLICY HOLDER DATE OF BIRTH | RELATIONSHIP TO PATIENT |
|---|---|---|
| | | |

## PreventionGenetics TEST INFORMATION

| TEST CODE | TEST NAME | TEST PRICE |
|---|---|---|
| | | |

| CPT CODE(S) | ICD-10 CODE(S) |
|---|---|
| | |

**CHECK IF THIS TEST IS** (check all that apply)**:**

☐ Exome ☐ Genome ☐ Duo ☐ Trio ☐ Prenatal

### ADDITIONAL REQUIREMENTS FOR PRE-AUTHORZATION / CLAIM FILING

☐ Relevant Medical Records addressing medical necessity and/or Letter of Medical Necessity

*In some cases you may be asked to provide additional information to our billing staff in order to process pre-authorization with the insurance company.*

### REQUESTER / ORDERING PROVIDER INFORMATION

| FACILITY NAME | DATE OF REQUEST (MM/DD/YYYY) |
|---|---|
| | |

| ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| CONTACT NAME | E-MAIL | PHONE |
|---|---|---|
| | | |

| ORDERING PROVIDER | NPI # | FAX |
|---|---|---|
| | | |