BAYLOR MIRACA GENETICS LABORATORIES

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STATEMENT OF MEDICAL NECESSITY FOR GENETIC TESTING

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

PATIENT NAME: ____________________ ____________________ ___
LAST NAME FIRST NAME MI

PATIENT DATE OF BIRTH: ____ / ____ / ____
MM DD YY

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/YY): ______________________________

ADDRESS: ______________________________

CITY, STATE, ZIP: ______________________________

PHONE: ______________________________