ARUP LABORATORIES

*A nonprofit enterprise of the University of Utah and its Department of Pathology*

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

# EXOME OR GENOME SEQUENCING PREAUTHORIZATION

**Submit this form with test order and patient history form. THIS IS NOT A TEST REQUEST FORM.**

**INSTRUCTIONS: If the ordering facility would like ARUP Laboratories to obtain insurance preauthorization prior to performing Exome Sequencing or Whole Genome Sequencing, complete this form and send it with the specimen. If preauthorization is granted, the client will be notified and testing will proceed; however, preauthorization is not a guarantee of payment. If preauthorization is denied, the ordering facility will be notified and given the option to cancel the test. DNA extraction will be performed for the patient and comparator sample(s) to ensure stability (ARUP will add DNA Extract and Hold; ARUP test 3005714 to each sample). A DNA extraction fee will only be charged once per sample.**

## Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, ZIP: _____

email: _____ Phone: _____

ICD Codes/Principle Diagnosis: _____

**Please submit a clinical chart note detailing the patient's phenotype.**

## Institution Information

Physician/Provider Name: _____ Physician NPI #: _____

Institution Name: _____ ARUP Client ID #: _____

Address: _____ City, State, ZIP: _____

email: _____ Phone: _____

Billing Facility Tax ID #: _____ Billing Facility NPI #: _____

## Patient Insurance Information

**Please include a copy of the insurance card (front/back)**

Member Name/DOB (Same as above? ☐): _____ Relationship to Patient: _____

Member Policy #: _____ Member Group #: _____

Insurance Company Name: _____ Phone: _____

Insurance Company Address: _____ City, State, ZIP: _____

**Patient Authorization/Assignment**

I authorize ARUP Laboratories Inc. to obtain and release relevant medical and other information to Medicare, Medicaid, Medicare Supplemental, and any other insurance providers for laboratory services that ARUP provides to me.

_____

Signature of Patient or Guardian (Required) Date

_____

Printed Name of Patient or Guardian (Required) Date

**Preauthorization (ARUP Use Only) #:** _____

## Test Information

3016583 Exome Sequencing (CPT code 81415, add 81416 for each comparator sample submitted)

3016493 Whole Genome Sequencing (CPT code 81425, add 81426 for each comparator sample submitted)