

Genetic Testing
Fax completed form to:
608-252-0863



Please complete this form if you are the individual providing genetic counseling services necessary to meet the WellFirst Health Plan medical policy requirements for pre and post genetic counseling requirements for certain tests. Attach this completed form to your online authorization or fax the completed form to 608-252-0863.

To be completed by Genetic Counselor:

WellFirst Health Plan Authorization Number		
Genetic Counseling Recommendation (choose one of the following):		
<input type="checkbox"/>	This individual meets WellFirst Health Plan’s Medical Coverage Policy Criteria and I support the testing requested.	
<input type="checkbox"/>	This individual does not meet WellFirst Health Plan’s Medical Coverage Policy Criteria for the testing requested and I recommend no genetic testing be performed at this time. This request should be denied.	
<input type="checkbox"/>	I recommend consideration of other genetic testing not typically approved by WellFirst Health Plan Medical Policy (Provide explanation below or in the “Additional Information” section of your online authorization):	
Genetic Counseling Attestation		
<input type="checkbox"/>	By checking this box and signing below, I affirm that I am a genetic clinical nurse, advanced practice nurse in genetics, board certified genetic counselor, a board-eligibility/board-certified clinical geneticist, or am a participating genetic counselor and I am not currently employed by a genetic testing laboratory.	
Signature:		Date:
Name (Print):	Phone:	Fax:

For further information on genetic testing, please see the Genetic Testing page at www.wellfirstbenefits.com.