PMCDx
Personalized Medicine Care Dx
Translate Genes To Your Health

PREAUTHORIZATION REQUEST FORM

Instructions: Please fill out all applicable sections completely and legibly. Please attach any additional documentation that is necessary for review, e.g. medical notes or patient visits, to support the prior authorization request.

ORDERING PHYSICIAN

Physician Name:		Physician NPI:	
Clinic Name:	Clinic Phone:	Clinic Fax:	
Clinic Address:	City:	State:	Zip Code:

PATIENT INFORMATION

First Name:	Last Name:	MI:	Date of Birth:
Address:	City:	State:	Zip Code:
Phone Number:	Email	Gender:	

INSURANCE INFORMATION

Primary Insurance Name:	Policy Number:	Group Number:
Relationship: ☐ Self ☐ Spouse ☐ Dependent	Insured's Name:	Insured's Date of Birth:
Secondary Insurance Name:	Policy Number:	Group Number:
Relationship: ☐ Self ☐ Spouse ☐ Dependent	Insured's Name	Insured's Date of Birth:

TEST INFORMATION

Test to be ordered:

INFECTIOUS DISEASE

- ☐ Gastrointestinal
- ☐ Nail Infection
- ☐ Respiratory Pathogen Panel
- ☐ STI Molecular Panel
- ☐ Urinary Tract Infection
- ☐ Wound Infection
- ☐ Vaginal Microbiota

PHARMACOGENOMICS

- ☐ Anesthesiology Panel
- ☐ ApoE Panel
- ☐ BPH Panel
- ☐ Cardiovascular Panel
- ☐ Cancer & Immunosuppressive Panel
- ☐ Endocrine & Metabolic Panel
- ☐ Gastrointestinal Panel
- ☐ Gout Panel
- ☐ Gynecology Panel
- ☐ Hyperuricemia Panel
- ☐ Hematology Panel
- ☐ Infectious Disease Panel
- ☐ Neurological & Psychiatric Panel
- ☐ Overactive Bladder Panel
- ☐ Pain Management Panel
- ☐ Xerostomia Panel
- ☐ Proactive Health (includes all panels)

GENETIC SEQUENCING

Choose a category:

- ☐ Cardiology
- ☐ Carrier screening
- ☐ Dental
- ☐ Dermatology
- ☐ Ear/Nose/Throat
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ Hematology
- ☐ Hereditary Cancer
- ☐ Immunology
- ☐ Malformations
- ☐ Metabolic disorder and newborn screening
- ☐ Muscular
- ☐ Nephrology
- ☐ Neurology
- ☐ Ophthalmology
- ☐ Pediatric genetics
- ☐ Proactive Health (includes common cancer & cardiac panels)
- ☐ Pulmonology
- ☐ Reproductive

Specify the panel below:

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ICD-10/Diagnosis Codes:

Additional Notes (optional):

Please send the completed form to billingoffice@pmcdx.com or fax it to (240) 477-7468. For any questions, please call (202) 802-8877.