Cigna Genetic Counseling Recommendation Form

This form, along with a 3-generation pedigree, copy of the Ordering HCPs Lab Requisition Form and a photocopy of your evaluation are required for consideration of this request. Please fax to Cigna @ 855.245.1104.

Customer (Patient) Information

Name:
ID#:
Date of Birth:
Date of Consultation:

Genetic Clinical Nurse (GCN), Advanced Practice Nurse in Genetics (APNG), Genetic Counselor or Clinical Geneticist Information

Name:	Tax ID:
Street Address:	Telephone:
City, State, Zip:	Fax:

Ordering Healthcare Professional Information

Name:	
Street Address:	Telephone:
City, State, Zip:	Fax:

Rendering Lab Information

Name:	
Street Address:	Telephone:
City, State, Zip:	Fax:

Requested Test(s) Information

Requested Test Name(s):	**CPT/HCPCS Code(s):**

Recommendation (Choose one of the following)

☐	This individual meets Cigna's Medical Coverage Policy criteria, and I support the testing requested.
☐	This individual does not meet Cigna's Medical Coverage Policy criteria, but I support the testing requested for the reason(s) listed below:
☐	I do not support the recommendation, but do recommend consideration of the following alternative testing (provide explanation below):
☐	This individual does not meet Cigna's Medical Coverage Policy criteria for the testing requested, and I recommend no genetic testing be performed at this time.
☐	This individual does NOT meet Cigna's Medical Coverage Policy criteria and has elected NOT to pursue testing at this time (provide explanation below):
☐	This individual does meet Cigna's Medical Coverage Policy criteria but has elected NOT to pursue testing at this time for reasons outlined below:
☐	I have no recommendation to make regarding the testing requested for the reason(s) described below.
	Reasons/Explanation:

☐ **By checking this box, I affirm that I am a Genetic Clinical Nurse (GCN), Advanced Practice Nurse in Genetics (APNG), board-certified Genetic Counselor or a board-eligible or board-certified Clinical Geneticist, and I am not employed by a commercial genetic testing lab.**

Signature

Signature:	Date:

Submission instructions

- **This completed form, along with a 3-generation pedigree, a copy of the Ordering HCP's Lab Requisition Form and a photocopy of your evaluation, are required for consideration of this request.**
- **Please submit this information via our secure fax number: 855.245.1104.**