Labcorp Use Only. Please place accessioning sticker here.

Eligibility (Preverification) & Prior Authorization Request for **Reveal® SNP Microarray**

Section A: Member/Patient Information

Patient's Name_____ / Date of Birth_____

Address_____ / City_____ / ST_____ / ZIP_____

Patient's Phone No._____ / ◯ Confidential voicemail / Patient's email_____

Section B: Requested Procedure or Service Information

Date of Sample Collection:

Test Name	Test No.
◯ SNP Microarray–Products of Conception (POC) / Tissue (Reveal®)	**510110**
◯ SNP Microarray–Prenatal (Reveal®)	**510100**
◯ SNP Microarray–Pediatric (Reveal®)	**510002**
◯ Other	**Other**

Required - ICD-10 Diagnosis Code(s)		

Section C: Ordering Provider Information

Provider Name (print) _____ / NPI: _____

Provider Account No. _____ / Telephone: _____ / Fax. _____

Address: _____ / City: _____ / ST: _____ / ZIP: _____

Account No. _____

Ordering provider signature: _____ / Date: _____

Section D: Prior Authorization Care Coordinator Information (use these details for correspondence concerning prior authorization)

Address/City/ST/ZIP: Prior Authorization Department: **PO Box 2230, Mail Stop 285, Burlington, NC 27216-0230**

Telephone: **(866) 248-1265** | Email: **PriorAuth@labcorp.com** | Fax: **(844) 890-0003**

Section E: Service Provider or Facility Information

Name: **Labcorp's Center for Molecular Biology and Pathology (CMBP)** | Phone: **(800) 533-0567** | Fax: **(844) 890-0003**

Address/City/ST/ZIP: **1904 TW Alexander Drive, Research Triangle Park, NC 27709** or **PO Box 2240, Burlington, NC 27216**

TIN#: **13-3757370** | NPI: ◯ **1033196001** ◯ **1902809940** | Place of service: **Outpatient Clinical Laboratory**

Section F: Insurance Benefits and Eligibility and Prior Authorization for Testing

Deductible Remaining: $ _____ | B&E Ref No: _____ | Prior Authorization Required: ◯ Yes ◯ No

Percentage of Test Covered: _____% | B&E Payer Rep: _____ | Prior Authorization Approved: ◯ Yes ◯ No

Expected Patient OOP: $ _____ | PA Payer Rep: _____ | Authorization No. _____

B&E Date: _____ | PA Date _____ | Valid From: ____/____/____ To: ____/____/____

THIS IS NOT AN ORDER FOR A LABORATORY TEST. By submitting this form, you acknowledge and understand that a preverification request to your patient's insurance provider will be submitted. Preverification is an estimate of level of coverage in advance of claim submission and is not a guarantee of payment. Eligibility is determined by the insurance provider at the time the claim is received and is subject to the limitations and exclusions of the applicable insurance plan. Once a claim is received by the insurer, actual coverage determinations will be based upon, among other things, your patient's eligibility and the terms of his or her certificate of coverage applicable on the date services were rendered. Specific questions regarding your patient's plan should be directed to his or her insurance provider. We will contact you by phone and/or fax at the numbers provided above to relay the insurance provider's response to this request.

Please complete Sections A, B and C and fax this form to **(844) 890-0003** along with the following:

1. Clinical Questionnaire for Reveal® SNP Microarray (available at labcorp.com/testmenu or womenshealth.labcorp.com)
2. Genetic counseling report and/or additional clinical notes, if available
3. Copy of front and back of insurance card(s)

Incomplete or missing information may delay the processing of this request.

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