ClariSure® postnatal SNP microarray
insurance pre-authorization request form

500 Plaza Drive
Secaucus, NJ 07094
QuestDiagnostics.com

Quest Diagnostics is pleased to offer pre-authorization of patient insurance benefits for the ClariSure® Postnatal SNP Microarray. Pre-authorization services are intended to be provided before the applicable testing is performed. To request pre-authorization, please complete this form and send it to the Quest Diagnostics Pre-Authorization Services Coordinator via fax at 1.949.668.7818 or email at Preauthorization_CMA@QuestDiagnostics.com to begin the process. Please call 1.866.374.3744 (9:30 AM – 6:00 PM ET or 6:30 AM – 3:00 PM PT) with any questions.

To be completed by physician/physician designee:

ICD-10-CM code and description:_____

Clinical presentation:_____

Patient name:_____ DOB:_____ Gender: ☐ Male ☐ Female

Patient address:_____

Patient phone #:_____ Primary contact name/relationship:_____

Patient's primary care physician:_____

Requesting physician NPI:_____

Physician requesting pre-authorization:_____ Client ID #:_____ Sub-client ID #:_____

Requesting physician phone #:_____

Requesting physician fax #:_____ Attention to:_____

Insurance co:_____ ID #:_____ Group #:_____

Name of insured:_____ Insurance company phone #:_____

Please attach a copy of the front and back of the patient's insurance card.

Scheduled procedure date:_____

- It would be helpful for pre-authorization purposes to include a **Letter of Medical Necessity** (templates can be found at QuestDiagnostics.com/CMA) as well as chart notes.
- If the patient has had previous chromosomal testing, **please include a copy of the results**.

Physician Attestation of Patient Authorization and Notification:
I hereby attest:

- the patient has authorized Quest Diagnostics to furnish the patient's insurer the information necessary to perform pre-authorization of ClariSure® Postnatal SNP Microarray.
- the patient has been informed of the following: **Pre-authorization does not constitute a guarantee of insurance payment or the amount of patient out-of-pocket expenses.**

Physician name and signature:_____ _____ Date:_____
(print) (signature)

For Quest Diagnostics use only:

Spoke to:_____ Call/form by:_____ Date:_____