## **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	T
Name:	Tax ID:
Street Address: City, State, Zip:	Telephone: Fax:
only, otalo, Elp.	
Ordering Healthcare Professional Information	
Name:	
Street Address:	Telephone:
City, State, Zip:	Fax:
Pandaring Lab Information	
Rendering Lab Information  Name:	
Street Address:	Telephone:
City, State, Zip:	Fax:
Requested Test(s) Information	ODT#10000 0 - 4-/-)
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.

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