GENETIC TESTING REFERRAL WORKSHEET

Attn: Genetic Testing Pre-D Coordinator
Toll Free Phone Number: 1-800-891-2520
Fax: 567-661-0846

Date of Request: _____

Member Name: _____ Paramount ID#: _____

DOB: _____ Paramount Secondary ID#: _____
(if applicable)

Referring Physician: _____Contact: _____

NPI: _____ Provider Billing Tax ID (TIN): _____

Phone #: _____ Fax #: _____

Diagnosis: _____ ICD-10 Code: _____

CPT Codes: _____

McKesson Z-Code™ Identifier: _____

Date of Procedure Testing: _____

Name of Facility: _____ NPI #: _____

Tax ID#: _____ Address: _____

City/State/Zip Code: _____

Phone #:_____ Fax #: _____

Please send the following information:

- Brief medical/clinical history
- Current signs and symptoms
- Results of any pertinent diagnostic testing

PLEASE NOTE: OHIO BENEFIT ADMINISTRATROS IS NO LONGER ABLE TO REVIEW FOR RETRO DATES OF SERVICE