



A UnitedHealthcare Company

Genetic Testing for BRCA Mutations

From _____

Reference # _____ Phone _____ Pages (including cover) _____

Please see the information form below. This information is required in order to review the requested procedure against the medical policy. The information will assist us in determining coverage of your patient's planned procedure.

An accurate decision cannot be made without this information.

UnitedHealthcare policies can be viewed in detail at umr.com. Select **Provider** and then select **Guidelines and policies** under **Additional resources**.

Patient's full name _____ Date of birth _____ / _____ / _____
MM DD YY

Male Female Member ID _____

Ordering physician _____

Physician address (including city, state, Zip code) _____

Date of sample collection _____ / _____ / _____ Diagnosis code(s) _____
MM DD YY

Requested test name _____ CPT code(s) requested _____

Please ensure that all the following information is included in clinical submitted:

1. Personal history of cancer including type of cancer and age of diagnosis
2. Family history of cancer including relationship, type of cancer and age of diagnosis
3. Any predictive calculator scores
4. Any relevant clinical information

Please upload clinical documentation along with this completed form to your portal at umr.com.