Retrogen, Inc.
Solutions for Functional Genomics

CLINICAL DIAGNOSTICS

Laboratory Test Pre-Authorization Form

Please complete this form prior to performing test. This information will be used to check for insurance eligibility and pre-authorization to test.

Instructions:

1. Please make sure all information is on this form before faxing/emailing it
2. Either fax to **(858) 455-7987** or email to **authorization@retrogen.com**
3. Retrogen will contact facility to verify patient's eligibility within 24 hours of receipt
4. If you do not receive a phone call or you need to talk to a representative, please call us at (800) 738-7643 and ask for the **Pre-Authorization Department**

Test Panel Number

Patient Information

Patient Name	DOB

Insurance Information

Insurance Provder	Billing Address
Phone Number	
ID Number	Group Number
ICD-10 Code	

Patient Risk Factors (NIPT Testing ONLY)

Mother > 35 years old?	☐ yes	☐ no	☐ other, specify:
Abnormal serum screen?	☐ yes	☐ no	☐ other, specify:
Personal or family history of aneuploidy?	☐ yes	☐ no	☐ other, specify:
Abnormal ultrasound?	☐ yes	☐ no	☐ other, specify:

Physician Office Information

Name of Physician Office:	Physician Name:
Physician Office Phone:	Physician Office Email:
Physician Office Contact:	
Insurance Card: ☐ Please check box indicating **copy of front and back of insurance card** is attached	