



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

GENE ASSAY/BIOMARKER PRECISION MEDICAL TESTING INFORMATION FORM

This form must be completed and signed by the ordering provider. Forms completed by the laboratory will not be accepted.

PROVIDER INFORMATION

Provider Name _____

Medicaid/NJ FamilyCare Provider ID _____

Provider Address _____

Provider Contact Name _____ Provider Contact Phone No. _____

BENEFICIARY INFORMATION

Beneficiary Name _____

Beneficiary Identification Name _____

Beneficiary Date of Birth _____

GENE ASSAY/BIOMARKER PRECISION MEDICAL TESTING INFORMATION

Date Ordered _____ CPT/HCPCS Code(s) _____

ICD-10 Diagnosis Code(s) _____

Gene(s) Tested (if applicable) _____

Type of Test (e.g., Common Variants, Full Sequence, Del/Dup): _____

Reason for Testing (e.g., clinical findings, family history, previous test results)

How will the results of this gene assay/biomarker precision medical test change/impact the future medical management of the patient?

To the best of my knowledge, the above information is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient

Authorized Provider Signature
(FD-431)

Title

Date
(Revised 103025)