Q1. Does the patient's age meet the policy's coverage criteria for this genetic test?  
(a) Yes (b) No (c) Not specified

Q2. Was the test ordered by a specialist or provider type approved by the policy?  
(a) Yes (b) No (c) Not specified

Q3. Does the patient’s clinical presentation meet the policy’s definition of medical necessity for this genetic test?  
(a) Yes (b) No (c) Not specified

Q4. According to the policy, does the patient's clinical presentation meet any recognized clinical guidelines that support the use of this genetic test?

(a) Yes (b) No

If Yes, which guideline(s) support coverage in this case according to the policy?

(a) ACMG  
(b) NCCN  
(c) ASCO  
(d) USPSTF  
(e) ISPD  
(f) Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(g) None of the above

Q5. Has the patient completed prerequisite evaluations required by the policy (e.g., CMA, panels)?  
(a) Yes (b) No (c) Not required

Q6. Has prior genetic testing ruled out diagnoses that would make this test redundant under the policy?  
(a) Yes (b) No (c) Unknown

Q7. Will this test impact clinical management according to the policy's definition of medical necessity?  
(a) Yes (b) No (c) Not specified

Q8. According to the policy, is this test excluded if a more targeted or specific genetic test (e.g., single gene or smaller panel) is available and clinically appropriate for this patient?  
(a) Yes (b) No (c) Not specified

Q9. Does the policy consider family history or consanguinity as supporting factors for coverage?  
(a) Yes (b) No (c) Not specified

Q10. Is this test intended for screening purposes, and is screening covered under the policy?  
(a) Yes (b) No (c) Only in certain risk cases

Q11. Does the policy require genetic counseling prior to or after this test, and was it provided?  
(a) Yes (b) No (c) Not specified

Q12. According to the policy, is repeat testing (e.g. reanalysis, follow-up testing) allowed for this patient scenario?  
(a) Yes (b) No (c) Only under certain conditions

Q13. Is prior authorization required for this test according to the policy?  
(a) Yes (b) No (c) Not specified

Q14. Is the CPT code for this test listed and covered in the policy?  
(a) Yes (b) No (c) Not listed  
If Yes, please specify the CPT code:  
Answer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q15. Does the patient have any special context covered in the policy (e.g., prenatal testing, pharmacogenetic testing, tumor testing, urgent testing)?  
(a) Yes (b) No (c) Not specified  
If Yes, please describe briefly:  
Answer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Q16. Final decision: Based on all policy criteria and patient information, is this test covered for this patient according to the insurance policy?  
(a) Yes (b) No (c) Not specified

Q17. What steps must be followed under the policy to submit the claim?

Answer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_