Montana Genetic Testing Financial Assistance Application

APPLICANT/FAMILY INFORMATION

Patient's Name:_____DOB: _____

SSN:_____Gender: ☐ M ☐ F Race: _____

Phone:_____Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Parent or Guardian Name (*if patient is a minor)*: _____

Phone:_____Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Medicaid ID, if Applicant is enrolled in Montana Medicaid or Healthy Montana Kids *Plus*: _____

Insurance Company Name: _____

Release of Information:
I certify that the information I have given is true to the best of my knowledge. I give permission to Shodair to make any necessary contacts to check my statements. I agree to allow providers to release any medical, social and insurance information about me (or my child) to Shodair upon request in order to process the application for genetic testing financial assistance. Once information is provided to Shodair, I hold the provider harmless for subsequent disclosures of this information by Shodair. If I knowingly give false information, I understand that I must reimburse Shodair for any costs incurred, and any assistance from Shodair will terminate. This release is effective for the current state fiscal year.
Revocation Statement: I understand I have the right to revoke the above authorization for the release of information at any time by contacting Shodair in writing.

_____ _____

Signature (Applicant or Legal Guardian)

PROVIDER INFORMATION

Provider Recommending Test: _____

Phone:_____Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Genetic Specialist: _____

Phone: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____

TESTING INFORMATION *to be completed by the provider recommending genetic testing*

Type of Test *please circle one*:

Heritable ☐ Microarray ☐ Cancer ☐ Other: _____

Genetic Test Requested & ICD-10 Code: _____

Performing Laboratory: _____ Actual or Estimated Cost: _____

Please explain how current signs, symptoms, or family history suggest a genetic condition:

Please explain how this test will provide a clinical benefit to the applicant and/or family:

Please initial each line below. By initialing these statements and signing this application you are attesting that the information in this application is true to the best of your knowledge and that the following statements are accurate:

_____ Pre and post genetic counseling will be provided to the Applicant

_____ The test will be performed at a CLIA certified laboratory

_____ The test is not considered experimental or investigational

_____ The test is recommended in place of (to confirm or rule out) a clinical diagnosis

Provider Signature: _____ Date: _____