

CHNCT GENETIC TESTING REQUEST FORM

Member's Name: _____ Member's DOB: _____

Member's ID #: Plan: Husky _____ Charter Oak _____

Date of Surgery: _____ Lab: _____

Referring Physician: _____ Name of Contact: _____

Phone: _____ Fax: _____

Name of Test: _____

Diagnosis Code: _____

Test Code: _____

Clinical notes must be faxed to CHNCT for review.
Please fax request to 203-265-3994. Thank You

****PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF
ALL CLINICAL INFORMATION TO PROCESS REQUEST****