



The Benefits of Better Health

Blepharoplasty Authorization

Date of request: _____ Anticipated service date: _____

Patient name: _____ Phone: _____

ID number: _____ Date of birth: _____

Member address: _____

Provider name: _____ Tax ID: _____

Address: _____

Contact: _____

Phone: _____ Ext: _____ Fax: _____

Primary diagnosis: _____

ICD-10 codes: _____

List all proposed CPT/procedure codes; please specify if bilateral or single: _____

IMPORTANT: In addition to this form, submit:

- (1) pre-operative ophthalmologic examination with visual field testing reports,**
- (2) tried and failed treatments,**
- (3) color photographs with front and side views,**
- (4) recent history and physical,**
- (5) letter of medical necessity, and**
- (6) operative/procedure report (post-procedure only).**

Mail completed form and supporting documents to:

GEHA
P.O. Box 4665
Independence, MO 64051

Fax: 816.257.3255 or email caremanagementsurgery@geha.com.

Questions: Call GEHA at 800.821-6136, Ext. 3100.

All benefit payments are subject to review for any applicable deductibles, coinsurance, maximums, medical necessity and patient eligibility on the date that the service is provided or the supply delivered.