GEHA
The Benefits of Better Health

Breast Reduction 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) current history and physical,
(2) clinical notes,
(3) tried and failed treatments,
(4) color photos with date stamp, and
(5) a letter of medical necessity.

Mail completed form and supporting documents to:

GEHA
P.O. Box 4665
Independence, MO 64051

Photos can be emailed to our secure email; please call for the email address.

Fax: (816) 257-3255

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.