Breast Reconstruction Authorization Form

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Purpose of this form
You can use this form to initiate your precertification request. The form will also help you know what supporting documentation is needed for GEHA to review your request.

How to complete the form
We recommend reviewing **GEHA's coverage policy for Breast reconstruction** before completing this form. You can find our coverage policies at **Provider resources**. These will allow you to see the criteria used to determine medical necessity and procedures that are not allowable.

For us to review your request properly and to avoid delay, you must complete all sections of the form and provide the necessary supporting documentation. If you have questions about the form or need assistance, you can speak with a surgical specialist at 800.821.6136, ext. 3100.

After you have completed the form
Our reviews are completed within 15 days from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health or ability to regain maximum function.

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Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Date of request: _____ Anticipated service date: _____

Patient name: _____ Phone: _____

Preferred pronouns: _____ (optional)

ID number: _____ Date of birth: _____

Member address: _____

Physician: _____

Tax ID: _____

Address: _____

_____

Contact: _____

Phone: _____ Ext. _____ Fax: _____

Facility: _____

Tax ID: _____

Address: _____

_____

Contact: _____

Phone: _____ Ext. _____ Fax: _____

DX: _____ ICD-10 code: _____

List all proposed CPT/procedure codes below:

CPT:	**Please circle one:**	**CPT:**	**Please circle one:**
	Right / Left / Bilateral		Right / Left / Bilateral
	Right / Left / Bilateral		Right / Left / Bilateral
	Right / Left / Bilateral		Right / Left / Bilateral
Date/Side of Mastectomy or Lumpectomy: ☐ Bilateral ☐ Left ☐ Right Date (s): _____			**Indication (s) for breast reconstruction:** ☐ Implant Failure ☐ Symmetry ☐ Unsatisfactory Breast Reconstruction ☐ Other: _____

Place of service: ☐ Inpatient ☐ Outpatient

Note: Inpatient stays require a separate authorization from the surgery.

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IMPORTANT: In addition to this form, submit:

__The most recent medical evaluation, including summary of medical history and last physical evaluation.

__Results from diagnostic imaging and laboratory tests pertinent to the diagnosis including genetic testing if applicable

__Surgical treatment plan including method of reconstruction, grafting or tissues to be used and implants to be used if applicable

__Letter of medical necessity

Submit completed form and supporting documents to:

GEHA
P.O. Box 21542
Eagan MN 55121

Fax: 816.257.3255 or
Secure 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.