Breast Reduction 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 Reduction mammoplasty (Breast-reduction)** 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 help, 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.

GEHA

Breast Reduction Authorization Form

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: _____

DX: _____ ICD-10 code: _____

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

Has the patient had persistent symptoms in at least 2 of the anatomical body areas below, directly attributed to macromastia and affecting daily activities for 6 months? ☐ Yes ☐ No

If "yes," list the 2 anatomical body areas: _____ _____

List the amount of breast tissue (not fatty tissue), in grams to be removed from each breast:

☐ Left breast: _____ ☐ Right breast: _____

Submit the following information including the authorization form:

__ Current history and physical
__ Serial medical records that demonstrate the extent of evaluation and management
__ Color photos with date stamp, (send to caremanagementsurgery@geha.com)
__ Women 40 years of age or older copy of mammogram within the last year
__ List of all therapeutic measures tried; (symptoms persistent despite at last a 12 week trial of therapeutic measures); and
__ Documentation of the surgical plan, including the amount of breast tissue proposed to remove. (The Schnur scale is available within the GEHA coverage policy for Breast reduction.)

Submit completed form and supporting documents to:

GEHA
P.O. Box 21542
Eagan MN 55121

Fax: 816.257.3255 or
Color photos to 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.