GEHA®

Hysterectomy 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.

Hysterectomy

Medical notes documenting the following:

- Primary indication for the hysterectomy
- Physician office notes which include the following:
    - Complete history and physical exam including OB/GYN, surgical and co-morbid medical condition(s), including thyroid disease
    - Symptoms attributable to pelvic disease, including:
        - Duration
        - Severity
        - Relation to menstrual cycle
        - Impact on activities of daily living (ADL)
    - Reports of relevant diagnostic evaluation, including:
        - Laboratory (including genetic testing results)
        - Pathology (including biopsy results)
        - Imaging includes Ultrasound, MRI, CT, etc.
    - Diagnostic procedures (e.g., endometrial sampling, PAP, laboratory studies, hysteroscopy, or D&C)
    - Reports of all attempted treatments attempted, declined, contraindicated, or failed or including dates and clinical response
    - Most recent cervical cytology normal or managed per guidelines
    - Clinicals documenting pregnancy excluded by negative HCG or HCG planned prior to procedure or sterilization by history or patient not sexually active by history
- Identify if use of laparoscopic power morcellation is planned

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.

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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: _____

Please submit one CPT for Hysterectomy medical necessity review: _____

Place of service: ☐ Inpatient ☐ Outpatient

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

Submit completed form and supporting documents to:

GEHA
P.O. Box 21542
Eagan, MN 55121

Fax: 816.257.3255 or
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.