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 21542
Eagan, MN 55121

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

Fax 816.257.3255, or email caremanagementsurgery@geha.com

*If the patient lives in Texas, call United Healthcare Choice Plus at 877.585.9643.

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.