



Nasal Surgeries 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) a complete history and physical,**
- (2) relative office notes to include any operative report, procedure report and pathology reports,**
- (3) X-ray/CT scan interpretation report,**
- (4) a letter of medical necessity,**
- (5) Documentation of pre-operative examination with inclusion of testing reports (e.g., CT scan, endoscopy, etc.), and**
- (6) a listing of all tried and failed treatments.**

Mail completed form and supporting documents* to: GEHA
P.O. Box 21542
Eagan, MN 55121

OR fax completed forms and documents to 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.