



Panniculectomy/Abdominoplasty 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: _____

IMPORTANT: In addition to this form, submit

- (1) a complete 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

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

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

Fax: 816.257.3255 or 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.