

**Review Request
for Mastectomy for Gynecomastia**

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 08/28/08	Policy Effective Date: 10/01/08	Provider Tool Effective Date: 8/10/09
-----------------------------------	---------------------------------	---------------------------------------

Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:

Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

Pre-operative photographs must be submitted. Only digital photography can accompany this tool if submitted electronically.

Please check all that apply to the member:

- Request is for a male over age 18, or 18 months after the end of puberty.
- Request is for mastectomy using liposuction.
- Tissue to be removed is glandular breast tissue and not the result of obesity, adolescence, or reversible effects of a drug treatment that can be discontinued. (This would include drug-induced gynecomastia remaining unresolved six months after the cessation of the causative drug therapy.)
Specify drug: _____
- Appropriate diagnostic evaluation has been done for possible underlying etiology.
- Patient has pain or tenderness directly related to the breast tissue and it is documented in the medical record.
- The pain has a clinically significant impact on activities of daily living and has been refractory to a trial of analgesics or anti-inflammatory agents (for a reasonable time period adequate to assess therapeutic effects).
List timeframe: _____
- Pre-operative photographs are provided.

Member has any of the following conditions: (check all that apply)

- Documented androgen deficiency
- Chronic liver disease that causes decreased androgen availability
- Klinefelter's syndrome (47XYY)
- Adrenal tumors that cause androgen deficiency or increased secretion of estrogen
- Brain tumors that cause androgen deficiency
- Testicular tumors causing androgen deficiency or tumor secretion of estrogen
- Endocrine disorders (e.g. hyperthyroidism)
- Other condition not listed above.
Please list: _____
- Request is due to legitimate concern that a breast mass is present that may represent breast carcinoma. (Mammography may be of value to determine the need for surgery in some instances).
- Other (please list): _____

Member's height: _____

Member's weight: _____

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name and Title of Provider or Provider Representative
Completing Form (Please Print)*

Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**