

## Review Request for Prophylactic Mastectomy

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: 02/26/09	Policy Effective Date: 04/22/09	Provider Tool Effective Date: 8/10/09
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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:	

**Please check all that apply to the member:**

Member has:

- Two or more first-degree relatives with breast cancer
- One first-degree relative and 2 or more second-degree or third-degree relatives with breast cancer
- One first-degree relative with breast cancer before the age of 45 and another relative with breast cancer
- One first-degree relative with breast cancer and one or more relatives with ovarian cancer
- One first-degree relative with bilateral breast cancer
- Two second- or third-degree relatives with breast cancer and one or more with ovarian cancer
- One second- or third-degree relative with breast cancer and two or more with ovarian cancer
- Three or more second- or third-degree relatives with breast cancer

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Please specify relatives addressed above:

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> Mother _____                    | Please list type of cancer: _____ |
| <input type="checkbox"/> Sister _____                    | Please list type of cancer: _____ |
| <input type="checkbox"/> Daughter _____                  | Please list type of cancer: _____ |
| <input type="checkbox"/> Aunt _____                      | Please list type of cancer: _____ |
| <input type="checkbox"/> Niece _____                     | Please list type of cancer: _____ |
| <input type="checkbox"/> Grandmother _____               | Please list type of cancer: _____ |
| <input type="checkbox"/> Grandchild _____                | Please list type of cancer: _____ |
| <input type="checkbox"/> Half sister _____               | Please list type of cancer: _____ |
| <input type="checkbox"/> First cousin _____              | Please list type of cancer: _____ |
| <input type="checkbox"/> Second cousin _____             | Please list type of cancer: _____ |
| <input type="checkbox"/> First cousin once removed _____ | Please list type of cancer: _____ |
| <input type="checkbox"/> Other (please list): _____      | Please list type of cancer: _____ |
- Presence of a BRCA1 or BRCA2 mutation in the patient consistent with a BRCA1 or BRCA2 mutation in a family member with breast or ovarian cancer
- Presence of lesions associated with an increased cancer risk. Such lesions include atypical hyperplasia and lobular carcinoma in situ (LCIS)
- Been diagnosed with breast cancer in one breast.
- Extensive mammographic abnormalities (i.e. calcifications) such that adequate biopsy is impossible.
- Other (please list): \_\_\_\_\_

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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.

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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.**