Breast Reduction
Prior Authorization Form

Please return completed form to the Utilization Management Department at (401)459-6023.

Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, www.nhpri.org for more detailed information about this benefit, authorization requirements, and coverage criteria.

MEMBER INFORMATION		
Member's Name:	Member's ID#:	Member's DOB:
PROVIDER INFORMATION		
Provider's Name:	Supplier ID or NPI #:	Date of Request:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:

CLINICAL INFORMATION			
CPT Code:	Units:	CPT Code:	Units:
Diagnosis:		Diagnosis Code:	

Describe symptoms; please include presence or absence of well-defined shoulder grooving, pain locations or other musculoskeletal conditions:

Describe medical treatment received for any persistent, long standing back, neck, shoulder or other musculoskeletal pain attributed to large breasts:	Dates of treatment (needs to be at least 6 weeks of treatment)	
	Start	End

For women >40, a mammogram must be completed within one year prior to surgery. Please submit report documenting no evidence of breast cancer with this request.

Has counseling regarding breast feeding occurred and is documented? Yes ❑ No ❑ Please comment on future plans for breast feeding:

Describe estimated removal of breast tissue, per breast:

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN	
Signature of Treating Physician:	Date:

NEIGHBORHOOD DECISION

Authorization is not a guarantee of payment.

Authorization #:	Dates of Service:	Services Approved:
UM Initials:	Notification Date:	Not Approved - Letter to Follow

Neighborhood Health Plan of Rhode Island
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Updated 7/2011, 7/2012, 9/2014, Reviewed 6/2013, 3/2016