



**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:	Provider ID # (Please call Provider Services for your ID #):	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		
Diagnosis & Diagnosis Code:		Procedure & Procedure Code:
Describe symptoms ; please include presence or absence of well defined shoulder grooving:		
Describe medical treatment received for any persistent, long standing back, neck, shoulder or other musculoskeletal pain attributed to large breasts:		<u>Pain or Other Musculoskeletal Conditions</u>
		<u>Treatment Received</u>
Has counseling regarding breast feeding occurred and is documented? Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 #:	Dates of Service:	Services Approved:
UM Initials:	Notification Date:	<input type="checkbox"/> Not Approved - Letter to Follow