SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Reduction Mammoplasty

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Member's height _____ Member's weight _____

The member is 18 years or older ..... ☐ Yes ☐ No

Estimated amount of tissue to be removed per breast _____

The member's Schnur Scale results _____

The member has significant physical functional impairment ..... ☐ Yes ☐ No

This procedure is expected to reasonably improve the physical and functional impairment ..... ☐ Yes ☐ No

The member has signs and/or symptoms resulting from the breast hypertrophy that have not responded adequately to any non-surgical interventions ..... ☐ Yes ☐ No

The member has any of these anatomical body areas affecting activities of daily living:

- Pain in upper back ..... ☐ Yes ☐ No
- Pain in neck ..... ☐ Yes ☐ No
- Pain in shoulders ..... ☐ Yes ☐ No
- Headache ..... ☐ Yes ☐ No
- Painful kyphosis documented by x-rays ..... ☐ Yes ☐ No

The member has severe submammary intertrigo or shoulder grooving with ulceration that is refractory to conventional medications and conservative measures for a period of 6 months or more ..... ☐ Yes ☐ No

There is documentation from a primary care physician and other providers, as appropriate (e.g. physiatrist, orthopedic surgeon), showing the diagnosis and evaluation of symptoms that prompted this request, which confirms all of the following:

- There is a reasonable likelihood that the member's symptoms are primarily due to macromastia ..... ☐ Yes ☐ No
- Reduction mammoplasty is likely to result in improvement of the chronic pain ..... ☐ Yes ☐ No

- Pain symptoms persist, as documented by the physician, despite at least a 3-month trial of therapeutic measure, such as:
  - Analgesic or non-steroidal anti-inflammatory drugs (NSAIDs) interventions. . . . . ☐ Yes ☐ No
  - Physical therapy, exercise, or posturing maneuvers . . . . . ☐ Yes ☐ No
  - Supportive devices (e.g. proper bra support, wide bra straps). . . . . ☐ Yes ☐ No
- Women 40 years of age or older are required to have a mammogram that was negative for cancer performed within the year prior to the date of the planned reduction mammoplasty. . . . . ☐ Yes ☐ No
- Date of mammogram (month/day/year) _____ /_____ / _____

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:	Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715-221-9918	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Customer Service at 1-800-548-1224.

