Reduction Mammoplasty

Prior authorization requests accepted from providers only.

Member/patient name: _____

Documentation of the following information:

- ☐ Female
- ☐ Please indicate the age of the patient_____
- ☐ Please check all of the following symptoms that apply and provide supporting documentation:
  - ☐ Pain in the upper back, neck and/or shoulders due to breast weight
  - ☐ Ulceration of skin of shoulder or shoulder grooving and/or persistent inertrigo not responding to conservative treatment including dermatological therapy
  - ☐ Neurological symptoms related to brachial plexus pressure
  - ☐ Thoracic kyphosis documented by x-ray
  - ☐ Occipital headache that is not attributed to other factors
- ☐ Estimated breast tissue to be removed. Weight in grams per breast:

  Right Breast_____ Left Breast_____

Please provide the following: HT: _____ WT: _____ BSA: _____

Please provide history and physical including onset of symptoms, diagnostic testing, Imaging, and treatment received, and response to treatment.

This is not an inclusive list. Additional information may be requested.

What do I do now?

Please fax this page and your completed Preauthorization Request Form to Health Services:
Fax: (541) 225-3625 Questions? Please call us toll-free at (888) 691-8209 or (541) 684-5584.

Where do I find the Preauthorization Request Form?

You'll find the Preauthorization Request Form at: PacificSource.com/provider/preauthorization.aspx