Reduction Mammoplasty Checklist

PacificSource HEALTH PLANS

Prior authorization requests accepted from providers only.

Member/Patient Name _____

Checklist

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 _____

Next steps

1. Please provide history and physical including onset of symptoms, imaging and treatment received, and response to treatment.
2. Complete this form and submit request online through InTouch at PacificSource.com/aboutproviderintouch. You'll find the Preauthorization Request Form at: https://pacificsource.com/sites/default/files/2021-05/PRV439_1020_PreAuthRequestForm-NonParProviders.pdf.

Questions? Please call us toll-free at **888-691-8209** or **541-684-5584**.

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