Harvard Pilgrim Health Care

Breast Surgery
Medicare Advantage Prior Authorization Request Form — Fax: 866-874-0857

Clear Form

ONLY COMPLETED FORMS CAN BE PROCESSED
Harvard Pilgrim reserves the right to request additional clinical information.
Incomplete forms or lack of supporting documentation may delay response time.

Please check the box below only if request meets the definition of "expedited."

☐ Expedited: Medicare defines expedited requests as those where "applying the standard time for making a determination could seriously jeopardize the enrollee's health, life, or ability to regain maximum function."

Patient Information	**Person Completing Form**
Patient name:	Name:
HPHC member ID #:	Phone #:
Date of birth:	Fax #:
Requesting Provider	**Servicing Provider/Facility**
Last name: _____ First name: _____ Title (NP, PA)	Last name: _____ First name: _____ Title (NP, PA)
HPHC provider ID #:	Address:
NPI #:	
Service start date: _____ Service end date	HPHC provider ID # (*if known*)
Diagnosis:	Tax ID #:
ICD-10 code:	
Service type: ☐ Inpatient ☐ Outpatient ☐ Observation ☐ Other	Number of visits/units requested:
Service location:	Authorization type:

Procedure Code(s)	
19316	Mastopexy
19318	Reduction mammoplasty
19318-50	Reduction mammoplasty, bilateral

(Continued)

Procedure	Criteria
Reduction mammoplasty related to mastectomy, lumpectomy etc.	Must have one: 1. Mastectomy 2. Lumpectomy 3. Excisional biopsy including any of the following: ☐ Breast cyst ☐ Benign or malignant breast mass ☐ Aberrant breast tissue ☐ Duct lesion ☐ Nipple or areola lesion ***Or:*** _____
Reduction mammoplasty not related to mastectomy, lumpectomy etc. Weight of tissue to be removed: _____ grams Body Surface area (BSA): _____	Must have ***all***: *Clinical documentation confirms history of* ***significant symptoms*** that have interfered with normal daily activities for at least 6 months (despite appropriate conservative management) ***and*** History of back and or shoulder pain unrelieved by ***any***: • Conservative analgesics (e.g. compresses, massages, nonsteroidal anti-inflammatory drugs [NSAIDs]), ***or*** • Supportive measures (e.g. garments, back brace), ***or*** • Physical therapy, ***or*** • Correction of obesity, ***or*** Arthritic changes in cervical or upper thoracic spine, optimmally managed with persistant symptoms and/or significant restriction of activity as ***any***: • Signs and symptoms of ulnar paresthesias, OR • Cervicalgia, ***or*** • Torticollis ***or*** • Acquired kyposis *Intertrigonous maceration or infection of the inframammary skin (e.g., hyperpigmentation, bleeding, chronic moisture, and evidence of skin breakdown), refractory to dermatologic measures, ***or*** Shoulder grooving with skin irritation by appropriate supporting garment

Please attach any applicable clinical documentation.

If you have any questions about this process, please contact the Medicare Advantage Provider Service Center at **888-609-0692.**