



HEALTHCARE COOPERATIVE

Common Ground Healthcare Cooperative
 PO Box 1630
 Brookfield, WI 53008-1630
 T: 877.825.9293 | F: 414.918.8038

Breast Reconstruction

Prior Authorization Request

Date _____

If this request is being done for the treatment of breast cancer, no prior authorization is required due to the Women’s Health and Cancer Rights Act of 1998, which includes coverage for both reconstruction and implants. This covers both affected and non-affected breast.

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Provider’s office <input type="checkbox"/> 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 has a history of mastectomy or lumpectomy Yes No
- Member has a ruptured implant(s) post augmentation without mastectomy Yes No
- Member is experiencing pain symptoms Yes No
- Will autologous fat grafting be used during surgery Yes No
- Member will have mastectomy or lumpectomy Yes No
- What donor sites will autologous fat injection or transfer come from _____

Will acellular demal matrices be used during surgery (supporting documentation for use of graft must be submitted) Yes No

If yes, what type:

- Alloderm Alloderm-RTU DermaMatrix FlexHD Strattice Other

Does member have Poland syndrome Yes No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. CGHC 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: Common Ground Healthcare Cooperative
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If you have any questions, please contact Customer Service at 1.877.514.2442.