



BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization/Predetermination Request for Reduction Mammoplasty

Please **fax** completed forms to **(816)502-4910**
If you have any questions please call (816)395-3989

Patient's Name	Physician's Name	
BCBSKC ID (NOT SS#):	Date of Service	
BCBSKC 8-digit Provider # or NPI#	Facility	
Contact Name	Contact Fax No.	Contact Phone No.

Reduction mammoplasty may be considered **medically necessary** for the treatment of macromastia

ICD-9 Codes _____ CPT or HCPCS Codes: _____
23-hr observation or other _____
Duration of condition _____

What are the member's symptoms for this condition, for example significant back, neck or shoulder pain, intertrigo between the pendulous breast and chest wall; etc. _____

If intertrigo exists, what powders or creams have been tried _____
Previous failed conservative treatments _____

Bra Size and Cup _____; Member's height: _____ Member's weight: _____
Number of grams to be removed: Right _____ Left _____

Photos are not necessary for review; The Operative Report will need to be submitted with your claim to verify Actual amount of tissue removed.

If this procedure is due to part of reconstruction after mastectomy for the diagnosis of breast cancer, per state mandate procedure is covered. Please submit only diagnosis code for breast cancer and the following CPT codes of 19318 (50), 19324 and 19140. We do not need photos or symptoms. This will assist in payment on claims.

For BCBSKC Use Only	
BCBSKC Authorization Number: _____	Date Span: _____ to _____
Medical Management Team Member Name: _____	

Please allow two (2) business days from date of receipt of all necessary information for determination.
Duplicate submissions slow the process.

All patient information is strictly confidential.
Incomplete forms will be returned.