Security Health Plan[SM]
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

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: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ 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

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By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan 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:	Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715-221-6616	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Customer Service at 1-800-472-2363.

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