Breast Reduction 1

Assessment

- Initial Contact Information: \textcolor{red}{NOT MET}
  - 1. Office Contact Name
  - 2. Provide direct phone number and extension to individual requesting authorization
  - 3. Office Fax Number

- Out of Network/Out of Plan: \textcolor{red}{MET}
  - 1. Who is requesting out of network/out of plan request? (None)
  - 2. What participating provider(s) has the member already seen?
  - 3. What were the participating provider's recommendations?
  - 4. Is the requested service available within the member's network/plan? (None)
  - 5. Please provide the rationale and any pertinent documents to support the request for out of network/out of plan services.

- Breast Reduction: \textcolor{red}{MET}
  - 1. Member's age
  - 2. Member's symptoms

- Additional Clinical Information to Support the Requested Service

- Confirm any relevant documentation to support the requested service has been attached or faxed to 913 664 5701. (None)

- If HAP is not the primary insurer for this patient, has the primary insurer already denied request/coverage? (None)

- "I certify the above information is entered for the right member, is true and accurate, and supported by medical records:" (None)

10/19/15