Medical Necessity Form:
Prophylactic Mastectomy or Oophrectomy

BlueCross BlueShield of Delaware

BCBSD requires that prior authorization for Prophylactic Mastectomy or Oophrectomy prior to the surgery. In order for BCBSD to gather relevant medical information for review, providers must complete and sign the form below. Completed forms should be faxed to BCBSD's Medical Management Department at ***302.421.8864*** or ***800.670.4862****.*

Patient Information		
Patient Name		
Patient's Date of Birth	**BCBSD Member ID Number**	**Proposed Date of Service**

Physician and Genetic Counselor Information		
Ordering Physician Name	**Phone Number**	**Fax Number**
Rendering Physician Name	**Phone Number**	**Fax Number**
Procedure Code	**Diagnosis Code(s)**	
Genetic Counselor Name	**Phone Number**	**Date of Visit**
Outcome: Surgery Recommended Y N	Patient Requested Surgery Y N	

Please check Y to those that apply to the patient (personal history) and/or the patient's family (family history, on either the mother or father's side). If Y is checked, please also list the relationship to the patient of the individual diagnosed (e.g., self, maternal aunt, sister, paternal cousin) and her age at diagnosis.

Hereditary Breast and Ovarian Cancer Syndrome			
Y N	Biologically related individual from a family with a known BRCA1 or BRCA2 mutation	**Relationship**	**Age at Diagnosis**
Y N	Personal history of breast cancer in the contralateral breast	**Relationship** Self	**Age at Diagnosis**
Y N	Family history of bilateral breast cancer	**Relationship**	**Age at Diagnosis**
Y N	Family history of ovarian cancer	**Relationship**	**Age at Diagnosis**
Y N	Lifetime risk of breast cancer based on model noted	**Model**	**Percent (%)**

Please provide any additional information regarding the reason for surgery:

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I confirm that information given on this form is accurate as of this date.

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Signature of Physician or Authorized Representative Date