

Prior Authorization Form

BCCHP requires prior authorization for MRI, LEEP, and Cervical Conization. Each case will be reviewed by the prime contractor in collaboration with the BCCHP Nurse Consultant and at times the Medical Advisory Committee (MAC). Please refer to the BCCHP fee schedule for reimbursement. BCCHP follows ASCCP guidelines for cervical cases.

BCCHP#:

Authorization #:

Client Name (Last, First, MI)		Date of Birth	Last four SS # (optional)	Chart Number
Referring Clinic Site		Referring Provider Name	Place of Service <input type="checkbox"/> Office <input type="checkbox"/> Hospital	Date of procedure
Specialty Clinic Site		Specialty Provider Name	<input type="checkbox"/> ASC	

Cervical Procedure Requests	Cervical Procedures		
	<input type="checkbox"/> Colposcopy with LEEP Biopsy (57460)		<input type="checkbox"/> Conization of cervix: <input type="checkbox"/> cold or <input type="checkbox"/> laser (57520)
	<input type="checkbox"/> Colposcopy with LEEP electrode conization (57461)		<input type="checkbox"/> LEEP (57522)
Cervical Procedure Requests	Pap Results	HPV Results	Colposcopy Results (For LEEP approval, ECC or biopsy results must be CIN 2 or higher, see ASCCP guidelines)
	<input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H	HPV High Risk Testing Pos <input type="checkbox"/> Neg <input type="checkbox"/>	<input type="checkbox"/> ECC Result <input type="checkbox"/> CIN 2 <input type="checkbox"/> CIN 3
	<input type="checkbox"/> LSIL <input type="checkbox"/> HSIL <input type="checkbox"/> AGC	HPV 16 & 18 genotyping Pos <input type="checkbox"/> Neg <input type="checkbox"/>	<input type="checkbox"/> Cervical Biopsy <input type="checkbox"/> CIN 2 <input type="checkbox"/> CIN 3

Breast Procedure Requests	Breast Procedures
	<input type="checkbox"/> MRI guided breast biopsy with placement of localization device (19085, 19086) <input type="checkbox"/> MRI guided placement of breast localization device (19287, 19288) <input type="checkbox"/> Breast Screening MRI unilateral (77046 without contrast, 77048 includes CAD w/ or w/o contrast) (only for high risk) <input type="checkbox"/> Breast Screening MRI bilateral (77047 without contrast, 77049 includes CAD w/ or w/o contrast) (only for high risk) <ul style="list-style-type: none"> • MRI should never be used alone as a screening tool. MRI should not be used as a diagnostic tool for a palpable mass. • BCCHP does not reimburse for MRI to determine extent of disease in a woman already diagnosed with breast cancer.
	CBE and Imaging Results (include report) <input type="checkbox"/> Palpable mass <input type="checkbox"/> Mammogram finding: <input type="checkbox"/> Ultrasound finding: <input type="checkbox"/> MRI finding: Suspicious <input type="checkbox"/> Indeterminate <input type="checkbox"/> <i>MRI guided biopsy and/or localization only approved when there is no sonographic evidence of the abnormality.</i>
Breast Procedure Requests	Breast Cancer Risk: Approval for screening MRI requires patient be assessed as high-risk for breast cancer. Risk assessment models approved by BCCHP include: Tyrer-Cuzick, BRCAPRO, Claus and BOADICEA. The Gail Model is not accepted by BCCHP. Was the Tyrer-Cuzick (IBIS) model used? ___Yes ___No If so, Lifetime Risk: _____% (20% or higher is considered high risk) If a different tool was used please list tool and result _____
	Screening contexts that do not require the use of an assessment tool (please check if applicable and provide notes): ___ Chest wall radiation before the age of 30 ___ Positive for BRCA mutation, or first-degree relative with BRCA mutation ___ History of genetic pre-disposition (e.g. Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndromes)
	Does the client have a history of breast cancer? ___Yes ___No Note: For clients with a history of breast cancer, BCCHP follows the recommendation of the oncologist or breast surgeon. Please provide chart notes with clinical recommendations. If specialist information is unavailable, communicate with prime contractor. BCCHP does not cover or reimburse for genetic testing, genetic counseling, or breast cancer treatment.

Provider Comments:

Provider Signature:	Print Name:	Telephone number:	Date:
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BCCHP Prime Contractor Use Only	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Reason	Date:
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