Breast Reduction Questionnaire

Name: **Date:**

Breast reduction surgery must be approved by your insurance carrier prior to scheduling surgery. Each insurance company has their own criteria that must to be met prior to reviewing for prior authorization. Please complete the following information to help us ensure your insurance company has all necessary information at the time of their review.

- **Please circle if you have any of the following symptoms:**

  Back pain Breast pain

  Neck pain Rashes under or between the breasts

  Shoulder pain Numbness or tingling in hand or fingers

  None

- **If you circled any of the above symptoms, have you tried any of the following therapies?** Yes / No

  If yes, please indicate date(s) and length of treatments.

  Physical therapy

  Chiropractic treatment

  Acupuncture

  Treatment for rashes

  Other

- **Have you discussed these symptoms with a health care provider?** Yes /No

  If yes, please provide the name (or clinic) of the health care provider

FOR OFFICE USE ONLY: Insurance Plan/Carrier:			
Medical Policy Printed/Attached: Y / N / No policy available			Is a PA required: Y / N
Height:	Weight:	Grams Required:	Is outside documentation required: Y / N
Shoulder Strap Grooving present on exam: Y / N			Notes:
Mammogram/US: Over age 40? Y / N	Done in last 1 year? Y / N		Is Mammogram/Ultrasound required: Y / N