□ **Kaiser Permanente**
2401 Merced Street
San Leandro, Ca 94577
Phone (510) 969-7758 Fax (510) 969-7881

□ **Washington Hospital West**
2500 Mowry Avenue Suite 130
Fremont, CA 94538
Phone (510) 790-1911 Fax (510) 505-9160

□ **Stanford Health Care Valley Care**
5725 West Los Positas Blvd Suite # 270
Pleasanton, CA 94588
Phone (925) 416-6738 Fax (510) 505-9160

FAX to: _____ **FAX # _____**

DATE: _____

On the form below, we have indicated what your patient needs from our Program. Please request an authorization from her medical group.

HMO AUTHORIZATION REQUEST for:

Patient: _____ Date of Birth _____
Insurance Name: _____ Group Name: _____

Date of Surgery: _____
_____Patient has a continued need for products due to Mastectomy (L R Bilateral)
_____Patient has a continued need for products due to Partial Mastectomy (L R Bilateral)

Qty: _____ #L8000 Surgical Bras **Diagnosis Code (ICD-10) _____**
_____ #L8030 Breast Prosthesis (Silicone)
_____ #L8035 Breast Prosthesis (Custom)
_____ #L8020 Breast Prosthesis (Foam)
_____ #L8015 External Breast Prosthesis Garment
_____ #S8424 Compression Sleeve (Ready-Made)
_____ #S8428 Compression Gauntlet (Ready-Made)
_____ #S8427 Compression Glove (Ready-Made)
_____ #A9282 Cranial Prosthesis

Authorization Must Include New NPI, Confirmation of PECOS Enrollment & ICD 10 Code

Fax to HERS Breast Cancer Foundation

Any questions, please call us at your corresponding location.
Thank you for your prompt attention so we may serve your patient and ours!