SUSAN G. KOMEN SAN DIEGO BREAST HEALTH DIAGNOSTICS AUTHORIZATION REQUEST

Patient must sign medical release naming Komen SD and all information must be completely legible and signed by provider.
Fax completed requests to 858-751-5760. For assistance, call (858) 573-2760x104.

Patient ____ **Date of Birth** ____________
Last Name First Name
Home Zip Code____ **Phone**_______________________

Gender
☐ Male
☐ Female
☐ Transgender
☐ Other

Ethnicity
☐ Cuban
☐ Dominican
☐ Puerto Rican
☐ Salvadorian
☐ Mexican/Mexican-American/Chicano
☐ Other Hispanic/Latino/Spanish Origin
☐ Not of Hispanic/Latino/Spanish Origin
☐ Other

Race
☐ White
☐ Black/African American
☐ Middle Eastern or North African
☐ Asian
☐ Pacific Islander/Native Hawaiian
☐ American Indian/Native Alaskan
☐ Other

Please contact Komen SD at (858) 573-2760 or lizzie@sdkomen.org
to provide feedback on your experience or to ask questions.

INFORMATION BELOW THIS LINE TO BE COMPLETED BY PRIMARY CARE STAFF ONLY

REQUESTED SERVICE (S)

CPT Code	**Description**	**Authorization Number***(Komen Use only)
		Expiration Date:

*Authorizations expire 90 days after the approval date. Additional services not listed here **MUST** be pre-authorized to receive payment. Contact the referring Primary Care organization for further authorization. If you are requesting an MRI please complete this form *and the MRI addendum*.

Working diagnosis for request: (ICD-10 codes)____

Provider is requesting services in accordance with the California Department of Public Health, Cancer Detection Program (CDP) algorithms for abnormal findings. For diagnostic algorithms see http://qap.sdsu.edu/index.html

Explanation:____
Diagnostic Provider__________________________Phone___________________Fax__________________
Address____
Referring Clinic/Organization____________________ Referring Physician____________________________
Address_________________________Phone______________________Fax______________________

QUICK SCREEN CERTIFICATION. Regarding the above named patient, please check TRUE or False to the following eligibility questions for the Komen San Diego Breast Diagnostics Services Program. TRUE ***to all*** indicates eligibility for assistance.

The patient is a resident of San Diego County ☐ True ☐ False
The Patient is at or below 300% FPL ☐ True ☐ False
The patient has ***no other health insurance*** ☐ True ☐ False
The patient is not eligible for Covered CA ☐ True ☐ False
The patient is not eligible for Medi-Cal ☐ True ☐ False
The patient is not eligible for EWC ☐ True ☐ False ☐Exception (This is an EWC patient that needs a service NOT covered by EWC)

I confirm that I have verified that the above named patient meets criteria for Breast Health Diagnostics Program funds and that the patient has signed a medical release naming Komen San Diego.

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Signature of staff completing form:______________________**Print name and title**__________________________
Phone number or email (to contact staff completing form):____

Authorization Status: ☐ Approved ☐ Denied Komen SD staff initials: Approval date:
Komen has authorized this referral request to pay at MediCare rates for **the above services only**. The authorization number **must** be on your claim to receive payment. Claims must be submitted within 60 days of the date of service. Please do **NOT** bill the patient.

In order to receive reimbursement, claims must be submitted within 60 days of date of service. Submit paper claims to:

Susan G. Komen San Diego 4699 Murphy Canyon Road, Suite 102, San Diego, CA 92123

Fax claims to: **(858) 751-5760**
Email claims to**: claims@sdkomen.org**

Revised 1/4/2019

SUSAN G. KOMEN SAN DIEGO BREAST HEALTH DIAGNOSTICS PROGRAM

MRI Authorization Request Form

This form is an addendum to the SUSAN G. KOMEN SAN DIEGO BREAST HEALTH DIAGNOSTICS PROGRAM AUTHORIZATION REQUEST form.

If you are requesting an MRI, this form must be completed in addition to the standard SUSAN G. KOMEN SAN DIEGO BREAST HEALTH DIAGNOSTICS PROGRAM AUTHORIZATION REQUEST form.

All information must be completely legible and the form signed by the provider prior to authorization.
Fax completed requests to (858) 751-5760. For assistance, call (858) 573-2760x104.

Please check the boxes that describe the reason for submitting this request for MRI for diagnostic purposes. MRI authorizations are limited to the following:

☐ The mammogram and/or ultrasound revealed an ill-defined, poorly localized suspicious, non-palpable lesion also referred to as problematic imaging finding.

☐ The mammogram or ultrasound are inconclusive or negative in a patient with a palpable lesion who has increased risk factors and/or increased breast tissue density defined as > 75% dense or heterogeneously dense or very dense.

Referring Clinic/Organization ______________________________**Referring Physician**______________________________

Address____**Phone**________________**FAX**_____________________

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