

HEALTHCHOICE

3545 NW 58th St., Ste 500, Oklahoma City, OK 73112
Phone: 1-405-717-8879 or toll-free 1-800-543-6044
FAX: 1-405-717-8947 or 1-405-717-8935

BRCA REQUEST

This form must be completed and accompany all requests. Incomplete forms will not be reviewed.

Billing Provider: _____ Date: _____

Billing Address: _____

TIN: _____ Contact Person: _____

Contact Phone #: _____ Fax #: _____

Ordering Physician: _____ DOB: _____

Patient: _____ Member ID #: _____

Primary Member: _____ Male Female

ICD Code(s): _____

CPT Code(s) Requested: _____

Specimen Collection Date: _____

Beginning Date of Service: _____ Ending Date of Service: _____

ANCESTRY: Western/Northern Europe Central/Eastern Europe Africa Near East/Middle East Ashkenazi
 Latin American/Caribbean Asia Native American Other _____

PATIENT PERSONAL HISTORY OF CANCER (Check all that apply)

- NO PERSONAL HISTORY OF CANCER
 BREAST, INVASIVE/AGE AT Dx: _____
 Bilateral Premenopausal Triple Negative (ER-, PR-, HER2- pathology)
 BREAST, DCIS/AGE AT Dx: _____
 Bilateral Premenopausal Triple Negative (ER-, PR-, HER2- pathology)
 OVARIAN/AGE AT Dx: _____
 OTHER: _____ AGE AT Dx: _____
 BONE MARROW TRANSPLANT RECIPIENT

FAMILY HISTORY OF CANCER (Please Indicate Relationship, Maternal or Paternal, Site of the Cancer, and Age at Diagnosis. Indicate if Bilateral, Premenopausal, or Triple Negative Breast Cancer)

NO KNOWN FAMILY HISTORY

RELATIONSHIP	MATERNAL	PATERNAL	CANCER SITE	AGE AT Dx
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Comments: _____

****All information on this form is required for review. Information provided is private and confidential.****

NOTE: These Benefits are applicable only if the patient is an eligible enrolled member of a HealthChoice plan. All benefits are subject to the deductible, coinsurance and policy provisions. Please verify benefits and eligibility by calling the medical claims administrator at 1-405-416-1800 or toll-free 1-800-782-5218.

Medicare Patients: If HealthChoice is the Medicare supplement insurance, authorization from HealthChoice is not required. Please contact Medicare.