

**ARKANSAS DEPARTMENT OF HEALTH  
AUTHORIZATION FOR PRIOR APPROVAL**



Patient's Last Name	First	Sex Female	Client ID No.
Date of Birth / /			
Service Requested	Requested by	Procedure code	Procedure date
1.			
2.			
3.			
<b>TO BE PROVIDED BY (Use BreastCare Provider Number)</b>			
Physician		Provider No.	
Group name		Provider No.	
Hospital		Provider No.	

**Please check the appropriate boxes:**

- |   |  |
|---|--|
| <input type="checkbox"/> Patient is 40-64 years of age.       | <input type="checkbox"/> Sentinel node biopsy neg  |
| <input type="checkbox"/> Tumor size is less than 1 cm.        | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Skin involvement, ulceration         | <input type="checkbox"/> HGSIL or AGC Pap smear result with one or more of the following conditions: |
| <input type="checkbox"/> Multicentricity                      | <input type="checkbox"/> Unsatisfactory colposcopy   |
| <input type="checkbox"/> Four or more involved axillary nodes | <input type="checkbox"/> Only CIN I confirmed on biopsy  |
| <input type="checkbox"/> Fixation                             | <input type="checkbox"/> Satisfactory colposcopy with no lesion                                      |
| <input type="checkbox"/> Satellite nodules, or                |  |
| <input type="checkbox"/> Inflammatory carcinoma               |  |

**NOTE:**

*BreastCare* will make payment only to those providers who participate in the *BreastCare* Program. Please forward individual copies of the authorization to the appropriate providers.

Payment for physician services and hospital/radiation therapy facilities will be made according to:

1. State guidelines and
2. Eligibility of the recipient at the time the service is provided. Services should be billed to ADH only for recipients whose eligibility has been verified.

**PRIOR AUTHORIZATION CONTROL NUMBER:**

This number must be entered on the claim form or payment will be denied. Service must be performed before the end of the patient's eligibility date, which can be found on the ID Card.

\_\_\_\_\_  
Authorized By

/ /  
Date