HealthChoice

2401 N. Lincoln Blvd., Ste. 300, Oklahoma City, OK 73105
Phone 405-717-8879 or 800-543-6044, ext. 8879
Fax 405-949-5459 or 405-949-5501

BRCA REQUEST

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

Requesting provider ______________________ Contact person ______________________

Phone ______________________ Fax ______________________

Servicing Facility Information

Facility name ______________________

Address ______________________

TIN ______________________ Contact person ______________________

Phone ______________________ Fax ______________________

Member ______________________ Member ID ______________________

Patient ______________________ DOB ______________________

☐Male ☐Female Collection date ______________________

ICD code(s) ______________________ CPT code(s) requested ______________________

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
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

****All information 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 toll-free at 800-323-4314. **MEDICARE PATIENTS**: If HealthChoice is the Medicare supplement insurance carrier, authorization from HealthChoice is not required. Please contact Medicare.

Rev. March 2021