

CHNCT SURGERY/PROCEDURE REQUEST FORM

Member's Name: _____ Date of Birth: _____

Member's ID: . Plan: Husky_____ Charter Oak_____

Date of Surgery: _____ Hospital: _____

Surgeon: _____ Name of Contact: _____

Phone: _____ Fax: _____

Name of Surgery: _____ Outpt: _____ Inpt: _____ #days: _____

Procedure Code: _____ Diagnosis Code: _____

Please Include the Following Information for Reduction Mammoplasty Surgery:

- Mailed Photos
- Chiropractor, Physical Therapy and or Orthopedics - Clinical information
- Consecutive treatment of Intertrigo
- Height: _____ Weight: _____
- Amount of tissue to be removed from each Breast

Clinical notes must be faxed to CHNCT for review.
Please fax request to 203-265-3994. Thank You

****PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF
ALL CLINICAL INFORMATION TO PROCESS REQUEST****