

CHNCT SURGERY REQUEST FORM

Member's Name: _____ Member's ID#: _____

Plan: Husky _____ SAGA _____ Charter Oak _____

Date of Surgery: _____ Hospital: _____

Surgeon: _____ Name of Contact: _____

Phone: _____ Fax: _____

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

Proc Code: _____ Diag 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****