meridianhealth
A WellCare Company
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Breast Cancer Screening Exclusion Form

Member Name: _____

Member ID#: _____

Date of Birth: _____

This member has had a bilateral mastectomy or two unilateral mastectomies.

Date of Bilateral Mastectomy: _____

Or

Date of First Unilateral Mastectomy: _____

Date of Second Unilateral Mastectomy: _____

Medical record documentation must be attached to exclude the member.

Provider Signature: _____ Date: _____

Please fax the completed form to 312-508-7213.

Thank you for your cooperation in this important matter. Please call the MeridianHealth Quality Improvement department at **312-705-2900** if you have any questions.