FAX from: HERS Breast Cancer Foundation
2500 Mowry Ave. Suite 130
Fremont CA 94538
Phone: 510-790-1911 Fax: 510-505-9160

FAX to: _____

Fax # _____

DATE: _____

Page ____of ____

On the form below, we have indicated what your patient needs from our Program. Please request an authorization from her medical group.

AUTHORIZATION REQUEST for:

Patient: _____ Date of Birth _____
Insurance Name: _____ Group Name: _____

Qty: ____ #L8000 Surgical Bras
____ #L8030 Breast Prosthesis (Silicone)
____ #L8020 Breast Prosthesis (Foam)
____ #L8015 External Breast Prosthesis Garment
____ #S8424 Compression Sleeve (Ready-Made)
____ #S8428 Compression Gauntlet (Ready-Made)
____ #S8427 Compression Glove (Ready-Made)
____ #A9282 Cranial Prosthesis

Authorization Must Include New NPI & Confirmation of PECOS Enrollment
Fax to HERS Breast Cancer Foundation

☐ **Washington Hospital (West)**
2500 Mowry Ave, Suite 130
Fremont, CA 94538
P 510-790-1911
F 510-505-9160

□ **Valley Care Medical Center**
5725 W. Las Positas Blvd, Suite 270
Pleasanton, CA 94588
P 925-416-6738
F 510-505-9160

Any questions, please call us at your corresponding location.
Thank you for your prompt attention so we may serve your patient and ours!

Information in this facsimile is confidential. If you received this in error, please fax or call us.