meridianhealth
A WellCare Company

1 Campus Martius, Suite 700
Detroit, MI 48226

888-437-0606
TTY: 711
www.mhplan.com

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: __________

Please attach applicable medical record documentation.

Provider Signature: __________________________________ Date: __________

Please fax the completed form to 313-202-0006.

Thank you for your cooperation in this important matter. Please call the MeridianHealth Quality Improvement department at 313-324-3700 if you have any questions.