REQUEST FOR AUTHORIZATION OF REFERRAL TO UROLOGY OR GENERAL SURGERY FOR CIRCUMCISION *(BEYOND THE NEWBORN PERIOD)*

Please complete this form and the standard referral form, attach supporting clinical documentation, and FAX to CPMG CUSTOMER SERVICE at (858) 309-7977. **CPMG cannot review your request without this information.**

Name of Referring Provider: _____ Phone #:_____

Member Name: _____

Member ID#: _____ DOB: _____

Referrals to Urology or General Surgery for the evaluation of circumcision beyond the newborn period are considered medically necessary when one or more of the following conditions are present (*please check all that apply):*

- ☐ Non-retractable foreskin in boys age 8 and over, unresponsive to PCP trial of Betamethasone 0.05% cream or ointment, BID for 8 weeks
- ☐ Presumed diagnosis of balanitis xerotica obliterans
- ☐ Two (2) or more episodes of balanoposthitis, documented in E.R., Urgent Care, or by a PCP
- ☐ Pathologic phimotic scarring of the foreskin - usually as a result of recurrent balanitis/balanoposthitis
- ☐ Documented ballooning of the foreskin with irritation of the glans
- ☐ One (1) or more episodes of documented paraphimosis
- ☐ Boys under two years of age with documented GU tract abnormalities
- ☐ Boys under two years of age and one (1) or more documented UTI, with or without underlying GU tract abnormalities
- ☐ Boys over two years of age with two (2) or more episodes of documented UTI
- ☐ Other (please be specific): _____

Supporting clinical documentation (e.g., progress notes) must be submitted with this authorization request.

Please phone CPMG Customer Service if you have any questions at 1-877-276-4543.