

Infertility Treatment Preauthorization Request Form - Commercial



Member/Provider Information	
Date:	Requesting Provider:
Member Name:	Requesting Provider ID #:
Member ID #:	Tax ID #:
Member DOB:	Office Contact Name:
Partner/Spouse DOB:	Office Contact Phone # and Ext:
	Office Contact Fax #:

Diagnoses Codes _____	
Treatment date change only? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, from _____ to _____

Patient Infertility History
How many intrauterine insemination cycles has this member received?
How many IVF, GIFT, ZIFT or low tubal ovum transfer cycles has this member received?

Procedure(s) Requested
ICD-10/CPT Code(s): _____
Please check the procedure(s) for which you are requesting coverage:
<input type="checkbox"/> Intrauterine insemination <input type="checkbox"/> In Vitro fertilization <input type="checkbox"/> Ovulation induction <input type="checkbox"/> Oocyte donation
<input type="checkbox"/> Donor insemination <input type="checkbox"/> PGD <input type="checkbox"/> Other (please specify) _____
Number of cycles requested _____
Anticipated length of therapy: From _____ to _____

Required Clinical Information for Preauthorization Request
<input type="checkbox"/> H & P
<input type="checkbox"/> HSG, or sonohysterosalpingogram dated within 2 years (For all IVF/FET cycles, current cavity evaluation within 1 year)
<input type="checkbox"/> LMP, Day 3 Labs (E2, FSH; dated within 6 months), AMH
<input type="checkbox"/> Semen Analysis dated within 1 year (Two dated within last 3 months for severe male factor infertility — ICSI)
<input type="checkbox"/> Carrier Screening Report for PGT requests
<input type="checkbox"/> Member will self-pay for PGT
<input type="checkbox"/> Previous infertility treatment records
<input type="checkbox"/> Other clinical information: _____

All medication/drug management requests are being reviewed by Express Scripts (ESI). Use these phone and fax numbers for ESI preauthorization requests: Call **877-417-5383** or fax to **877-251-5896**

All non-medication/drug management requests: Fax this form and medical documentation to Clinical Review at **800-923-2882** or **860-674-5893** or call **800-562-6833** with any questions.

Please Note:
Services are not considered authorized until ConnectiCare issues an authorization.
Lack of information will delay processing of request.

Please note all requests must also include both a completed form and supporting medical documentation.

*This is confidential information. If you receive this form in error, please notify Provider Services immediately at **800-828-3407**.*