

Assisted Reproductive Technology Pre-Treatment Form



INSTRUCTIONS

To facilitate prompt review of your service request, please complete all items on this form. If not applicable, enter N/A. This review is to determine medical necessity **ONLY**.

Please fax completed form to 410-505-6884.

If you have questions about this form, contact your Professional Provider Relations Representative.

Prior to requesting review, please call the provider services number on the member's ID card to determine eligibility and benefits.

| | | | |
|---|------------------------------|--|--------------------------|
| Patient's Name | | Spouse's Name | |
| Membership ID Number | | Date of Marriage | Patient's DOB |
| Please describe in detail the patient's (and spouse's, if applicable) history in terms of duration and cause(s) of infertility. If additional space is needed, attach a separate sheet of paper. | | | |
| | | | |
| Primary Diagnosis and Code | Secondary Diagnosis and Code | Secondary Diagnosis and Code | |
| Parity History | | Years of Infertility | |
| Please check the items below (if applicable) and indicate the date where appropriate. | | | |
| Vasectomy: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: | | Reversal <input type="checkbox"/> Yes <input type="checkbox"/> No Date: | |
| Tubal Ligation: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: | | Reversal <input type="checkbox"/> Yes <input type="checkbox"/> No Date: | |
| Birth Control: <input type="checkbox"/> Yes <input type="checkbox"/> No Type Used: | | Date last used: | |
| Please document all tests and/or surgical or medical treatments related to fertility that have been performed on the member and/or spouse by circling the items below. Please attach all test results. | | | |
| FSH: | | Hysteroscopy: | |
| Estradiol: | | Post Coital: | |
| Sperm Antibody: | | Tuboplasty: | |
| Endometrial Biopsy: | | Serum Pregesterone: | |
| Laparoscopy: | | Hysterosalpingography: | |
| Semen Analysis: | | Basal Body: | |
| Other: | | | |
| FOR INTERNAL USE ONLY: | | | |
| Authorization Number: | Services Approved: | Number of Cycles: | Authorization Time Fram: |

Please use the section below to describe infertility treatments(s) that the member has received in the PAST.

| Treatment | Dates | Outcome |
|---------------|-------|---------|
| AI/IUI | | |
| | | |
| | | |
| IVF/GIFT/ZIFT | | |
| | | |
| | | |

Planned Services

Check services planned and circle or provide CPT code (if not listed):

| | | | | |
|--|---|--|--|--------|
| AI/IUI: <input type="checkbox"/> 58321 <input type="checkbox"/> 58322 | IVF/ZIFT/GIFT: <input type="checkbox"/> 58974 <input type="checkbox"/> 58976 | ICSI (semen analysis required): <input type="checkbox"/> 89280 <input type="checkbox"/> 89281 | Assisted Hatching: <input type="checkbox"/> 89253 | Other: |
|--|---|--|--|--------|

What existing sterility factors are present to indicate In-vitro fertilization (IVF)?

| | | | | |
|----------------|----------|-----------|------------|-----------|
| Endometriosis: | State I: | Stage II: | Stage III: | Stage IV: |
|----------------|----------|-----------|------------|-----------|

| | | |
|----------------|------|--|
| Tubal Disease: | DES: | Male Factor (semen analysis required): |
|----------------|------|--|

Other:

Identify sperm source: Spouse: _____ Domestic Partner: _____ Other: _____

Identify ova source: Patient: _____ Domestic Partner: _____ Other: _____

Identify host source: Patient: _____ Surrogate: _____

| | |
|-------------------------------|--|
| Number of Attempts Requested: | Dates of Requested Services Start date: _____ End date: _____ |
|-------------------------------|--|

Provider Information

| | |
|----------------|-----------------|
| Provider Name: | Contact Person: |
|----------------|-----------------|

| | |
|---------------------|----------------------------|
| Provider Signature: | CareFirst Provider Number: |
|---------------------|----------------------------|

Practice Name:

Practice Address:

| | | |
|------------------------|----------------------|--------------------------|
| Provider Phone Number: | Provider Fax Number: | Provider E-mail Address: |
|------------------------|----------------------|--------------------------|

Claim will be submitted on (check all that apply): CMS1500 (Professional charges) UB04 (Facility Charges)

If any service will be billed by other providers or vendors (such as labs, radiology, etc.), please identify those services and the provider/vendor who will bill.

| Services: | Provider/Vendor: |
|-----------|------------------|
| | |
| | |
| | |
| | |

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