

Assisted Reproductive Technology Pre-Treatment Form



All items must be completed on this form to facilitate prompt review of your service request. If not applicable enter N/A. This review is to determine medical necessity only. Please fax completed form to 410-505-6884. Prior to requesting review, please contact the provider services number on the member's card to determine eligibility and benefits.

1. Patient's Name	2. Spouse's Name
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2. Membership No.	4. Date of Marriage	5. Patient's DOB:
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6.. Please describe in detail patient's and spouse's (if applicable) history in terms of duration and cause(s) of infertility. If additional space is needed, please attach a separate sheet of paper.

7. Primary Diagnosis and code:	8. Secondary Diagnosis and code:	9. Secondary Diagnosis and code:
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10. Parity History:	11. Years of Infertility:
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12. Vasectomy	Yes	No	Date:	Reversal	Yes	No	Date:
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13. Tubal Ligation	Yes	No	Date:	Reversal	Yes	No	Date:
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14. Birth Control	Yes	No	Type Used:	Date Last Used:
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15. Please document below all tests and/or surgical or medical treatments related to infertility that have been performed on the member and/or spouse. Please include test results or attach test results.

FSH:	Hysteroscopy:
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Estradiol:	Post Coital:
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Sperm Antibody:	Tuboplasty:
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Endometrial Biopsy	Serum Progesterone:
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Laparoscopy:	Hysterosalpingography:
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Semen Analysis:	Basal Body:
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Other:

For Internal Use Only:

Authorization Number	Services Approved	Number of Cycles	Authorization Time Frame

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16. Please complete the following section to describe infertility treatment that the member has received in the past .				
Treatment	Dates:	Outcome:		
AI /UI				
IVF/GIFT/ZIFT				
Planned Services				
17. Circle services planned and circle or provide CPT code if not listed:		AI/UI 58321 58322	IVF/ZIFT/GIFT 58974 58976	
ICSI (semen analysis required) 89280 89281	Assisted Hatching: 89253	Cryo 89258	PGD 89290 89291	Other
18. What existing sterility factors are present to indicate In Vitro fertilization?				
Endometriosis	Stage I	Stage II	Stage III	Stage IV
Tubal Disease		DES	Male factor (semen analysis required)	
Other:				
19. Identify sperm source:	Spouse	Domestic Partner	Other	
20. Identify ova source:	Patient:	Domestic Partner	Other	
21. Identify host uterus:	Patient:		Surrogate:	
22. Number of attempts requested:				
			Dates of requested services:	
			Start:	End:
23. The following provider information must be completed:				
Provider Name:		Contact Person:		
Provider Signature:				
CareFirst BlueCross BlueShield Provider Number:				
Name of Practice:				
Provider Address:				
Provider Phone:		Provider Fax:	Provider E-Mail:	
24. Claim will be submitted on: circle all that apply:		CMS1500 (Professional charges)	UB04 (facility charges)	
25. If any services will be billed by other providers or vendors, such as labs, radiology –please identify those services and the provider /vendor who will bill .		Services	Provider/Vendor	

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