

Assisted Reproductive Technology Treatment Extension 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. Prior to requesting review, please contact the Provider Services number on the back of the member's card to determine eligibility and benefits. Fax completed form to 410-505-6884.

1. Patient's Name:	2. Spouse's Name:	
3. Membership No.:	4. Authorization number:	5. Patient's DOB:
6. Services approved under auth number listed in question #4: AI / IUI IVF/ ZIFT / GIFT	7. Number of cycles approved under this authorization number listed in question #4.	
8. Other services approved under authorization number listed in question #4. Please explain:	9. Number of cycles completed under authorization number listed in question #4:	

10. Please circle the reason for the requested extension:

A - More time is needed to complete services already approved

B - All services have been used – requesting more AI/IUI or IVF/ZIFT/GIFT

C - Request that services be added to authorization – ICSI, Assisted Hatching, Cryo

D - Other (please explain clearly)

For Internal Use Only:

Authorization Number:	Services Approved:	Number of Cycles:	Authorization Time Frame:

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