

Assisted Reproductive Technology Pre-Treatment Request

INSTRUCTIONS

Please contact CareFirst Provider Services using the number located on your patient's insurance ID card to determine eligibility and benefits prior to requesting a review for authorization. To facilitate prompt review of your service request, please **complete all fields** on request form. Forms without all fields completed will delay a response. This review is to determine medical necessity ONLY.

Participating Providers: to initiate a request and to check the status of your request, visit CareFirst Direct at carefirst.com.

If you have questions, call Pharmacy at 866-814-5506.

Fax completed form and supporting documentation to 866-249-6155.

PATIENT INFORMATION

Patient's Name	Date of Birth	Insurance ID #
Address	City/State/ZIP	
Spouse's Name		

DIAGNOSIS

Primary Diagnosis	ICD-10	Secondary Diagnosis	ICD-10
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PATIENT HISTORY

Years of Infertility	Parity History Gravida # _____ Para # _____
Past Birth Control Method Used	Date of Last Use
Infertility History Narrative (duration, causes, etc.)	

SURGICAL HISTORY

Procedure	Date	Reversal
Tubal Ligation		Yes No
Vasectomy		Yes No

PREVIOUS INFERTILITY TREATMENT

Treatment	Number of Cycles	Dates of Treatment	Cycle Outcome
Clomid Cycles			
IUI/Clomid Cycles			
IUI/Gonadatropin Cycles			
IVF Cycles			

PLANNED SERVICES							
AI/IUI	IVF/GIFT/ZIFT	ICSI	CRYO		Assisted Hatching	PGD	PGS
58321	58974	89280	89258	89254	89253	88291	81479
58322	58976	89281	89337	89335			

IVF SERVICES							
What existing sterility factors are present to indicate IVF? Endometriosis Tubal Disease Male Factor (S/A Required) DES Other: _____							
Sperm Source: Spouse Donor Ova Source: Patient Donor Host Source: Patient Surrogate							

PROVIDER INFORMATION	
Provider Name	Practice Name
Practice Address	Contact Person
Telephone #	Fax #
Email	CareFirst Provider #

ANCILLARY SERVICE PROVIDER(S)—PLEASE COMPLETE THIS SECTION IF PATIENT WILL USE A SEPARATE FACILITY FOR LAB WORK, MONITORING, ETC.	
Provider/Facility Name	TIN #
Provider/Facility Address	
Telephone #	Fax #
Procedure Codes That Apply To This Location	
Provider/Facility Name	TIN #
Provider/Facility Address	
Telephone #	Fax #
Procedure Codes That Apply To This Location	

FOR INTERNAL USE ONLY			
Authorization #	Services Approved	Number of Cycles	Authorization Period