# Assisted Reproductive Technology Pre-Treatment Request

CareFirst Family of health care plans

## 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/Partner Name (if applicable) | | |

## DIAGNOSIS

| Primary Diagnosis | ICD-10 | Secondary Diagnosis | ICD-10 |
|---|---|---|---|
| | | | |

## PATIENT HISTORY

| Years of Infertility | Parity History<br>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 /Gonadatropin Cycles | | | |
| IVF Cycles/Embryo Transfer | | | |
| Egg Retrievals | | | |





CUT9046-1E (5/25)

## 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 |
|---|---|---|---|
| | | | |