



**OSU Health Plan Infertility Request Form**

Submit completed form with supporting documents to:

[UtilizationManagement.OSUHealthPlan@osumc.edu](mailto:UtilizationManagement.OSUHealthPlan@osumc.edu) or Fax to 614-292-2667

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|--|--|
| <b>Patient Information</b>   |  |
| Name of Covered Person (Patient):  | Health Plan ID:  |
| Date of Birth:   | Assigned Gender at Birth:  |
| Identified Gender:   | If this is an extension, please provide previous authorization number:                               |
| <b>Provider Information</b>  |  |
| Name of Treating Provider:   | Address:   |
| TIN:   | Contact Name:  |
| Phone Number:  | Fax Number:  |
| <b>Clinical History</b>  |  |
| Date of Initial Visit:   | Date of LMP:   |
| Type of Contraception and Dates Utilized:  |  |
| Does the Covered Person currently have a partner?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | Is the partner <input type="checkbox"/> Male <input type="checkbox"/> Female<br>Partner's Full Name: |
| Is the Covered Person currently trying to conceive with their current partner? <input type="checkbox"/> Yes <input type="checkbox"/> No  | If yes, how long has the Covered Person been trying to conceive with this partner?                   |
| Is there a history of sterilization for the Covered Person?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | If yes, type of procedure and date:  |
| Is there a history of sterilization for the partner?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | If yes, type of procedure and date:  |
| Is there a history of fertility treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| If yes, please provide the date, type of procedure, and outcome:   |  |
| If Covered Person is currently undergoing active treatment, please provide the following:<br>Date of last cycle:<br>Last dose of medication (e.g., clomid, letrozole, Gonal-F, etc.):<br>Date of next planned cycle: |  |
| <b>Billing Information</b>   |  |
| ICD-10 Code(s):  |  |
| Treatment recommended:   |  |

**The following documents must be submitted with this form:**

- Progress notes documenting infertility as defined in the OSU Health Plan Infertility Treatment Policy.
- Sperm counts, ultrasounds, and other supportive documentation when applicable to the case.
- Referral to High-Risk OB / Maternal Fetal Medicine with initial authorization request for members with morbid obesity (BMI= $\geq$ 40).
- Unmedicated day 3 FSH level within the past 12 months.

NOTICE: This message is intended for the use of the individual(s) to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify the sender immediately and delete the related message.