MASSACHUSETTS

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Provider Service Request Form for Assisted Reproductive Technology Services MP 086 or Preimplantation Genetic Testing MP 088
Requests for BCBSMA Members, please fax to 1-800-836-1112 Requests for BCBSMA employees, please fax to 617-246-4299

Provider Name: _____ **NPI:** _____
Facility Name: _____ **Facility NPI:**_____
Provider Contact Name: _____ **Phone#**_____ **Fax #**_____

Patient Name: _____ **Date of Birth:** ____/____/____
BCBSMA Subscriber Name: _____ **ID Number:**_____
Partner's Name: _____ **Date of Birth:** _____/____/____

Member undergoing Chemotherapy or other treatment that is expected to render them infertile ❒
Ovulatory disorder❒
Ovulatory Disorder with exposure to sperm without conception for 6 cycles <35 ❒ ***OR*** 3 cycles ≥35 ❒
Biological female with no biological male partner with exposure to sperm (IUI) for 6 cycles <35 ❒ ***OR*** 3 cycles ≥35 ❒
Biological female with biological male partner inability to conceive, 12 months <35 ❒ ***OR*** 6 months ≥35 ❒
Has either partner been sterilized? Yes ___ No ___ ***OR*** Has either partner had a sterilization reversal? Yes___ No___
Has member smoked in the last year? Yes___ No___ Cotinine level: Member_____ Partner_____ (within 1 month of request)
Infertility Diagnosis (including IDC-10 code): _____
Treatment to date (including dates and outcomes):

Anticipated medically necessary procedures: (check ONLY the requested procedure)
❒ IUI to IVF conversion ❒ IVF ❒ IVF Freeze all ❒ IVF/FET (≤34yrs) ❒ Frozen Embryo Transfer (FET) (include # of frozen eggs/embryos remaining____) ❒ Frozen egg fertilization and transfer ❒ Donor Egg /Embryo ❒Purchased Donor Egg (MIB/DEB) ❒ Assisted hatching ❒ICSI ❒ Donor sperm ❒ MESA ❒ TESE ❒ Fertility preservation (egg/embryo/sperm cryopreservation)
❒ PGT-M (PGD) or PGT-SR (PGD): specific genetic dx: _____
❒ Early Pregnancy Monitoring (EPM) (*HMO plans only*)

Please check only the requested procedure *(the following are covered only if specified in the member's subscriber certificate/rider):*
❒ *Elective* Egg, Embryo or Sperm retrieval, freezing and storage ❒ PGT-A (PGS) ❒ Reciprocal IVF

Diagnostic Tests required: Please attach copies:
CCCT testing with appropriate dosing amounts: Day 3 FSH E2, clomid 100 mg P.O. day 5-9, and a day 10 FSH E2. CCCT (for > 39 and < 44 years old required yearly ***AND*** Day 3 FSH/Estradiol every 6 months in between Day 3 FSH and Estradiol (highest and most recent)

Must include one of the following: HSG/Hysteroscopy (for IUI) *OR* Uterine cavity evaluation (sonohysterogram/HSG, HyCosy, 3D ultrasound or Hysteroscopy, yearly.

Semen Analysis (for ICSI we only accept Kruger Morphology and there must be at least 2 samples, see medical policy #086 for details).