

# Infertility Benefit Information

PATIENT NAME: \_\_\_\_\_ PT# \_\_\_\_\_

EXCLUSIONS:	Donor Egg	Donor Sperm	Cryo	IVF	IUI
DX TESTING:	YES	NO	Lifetime Max	_____	
TX TO CORRECT:	YES	NO	Lifetime Max	_____	
IUI COVERAGE:	YES	NO	# Of Attempts	_____	
IVF COVERAGE:	YES	NO	Lifetime Max	_____	
SPOUSE COVERED:	YES	NO	Lifetime Max	_____	
MEDS COVERED:	YES	NO	Lifetime Max	_____	

Follistim	<input type="checkbox"/>		<input type="checkbox"/>	Prior Authorization
Gonal-F	<input type="checkbox"/>		<input type="checkbox"/>	Prior Authorization
Ovidrel	<input type="checkbox"/>		<input type="checkbox"/>	Prior Authorization
HCG	<input type="checkbox"/>		<input type="checkbox"/>	Prior Authorization
Cetrotide	<input type="checkbox"/>		<input type="checkbox"/>	Prior Authorization
Ganirelix	<input type="checkbox"/>		<input type="checkbox"/>	Prior Authorization
Anastrozole	<input type="checkbox"/>		<input type="checkbox"/>	Prior Authorization
Leuprolide	<input type="checkbox"/>		<input type="checkbox"/>	Prior Authorization
Crinone	<input type="checkbox"/>		<input type="checkbox"/>	Prior Authorization
Progesterone Oil	<input type="checkbox"/>		<input type="checkbox"/>	Prior Authorization

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Insurance Verification Form**

**Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**REACH Doctor** \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_

**Subscriber ID#** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Referral Required** \_\_\_\_\_ **PCP** \_\_\_\_\_

**Insurance Ph #** \_\_\_\_\_ **EFF.** \_\_\_\_\_

**Plan Design** \_\_\_\_\_ **DED** \_\_\_\_\_ **MET** \_\_\_\_\_

**Specialist Copay** \_\_\_\_\_

**Pharmacy Co.** \_\_\_\_\_ **Pharmacy #** \_\_\_\_\_

**IUI:** Prior Authorization YES or NO

**Prior Auth. Phone#** \_\_\_\_\_

**Surgical Benefits**

**Outpatient Surgery:** Pre-Cert Required YES or NO

**Inpatient Surgery:** Pre-Cert Required YES or NO

**Pre-Cert Phone #** \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_