MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Electrolysis for Gender Affirming Services (Transgender Services)
Prior Authorization Request Form #902
Medical Policy #189 Gender Affirming Services (Transgender Services)

Please use this form to assist in identifying members who meet Blue Cross Blue Shield of Massachusetts' (BCBSMA's) medical necessity criteria for continued electrolysis or laser hair removal following Gender Affirming Services.

Note: Electrolysis or laser hair removal is only covered for the removal of hair on skin being used for genital gender affirmation surgery.

Once completed, fax to:

BCBSMA Members: **1-888-282-0780**	**Medicare Advantage Members:** **1-800-447-2994**	**BCBSMA Employees:** **1-617-246-4299**

Patient Information	
Patient Name:	Today's Date:
BCBSMA ID#:	Date of Treatment:
Date of Birth:	Surgical Date:

Physician Information	**Facility Information**
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax#:	Fax#:
NPI#:	NPI # if applicable:

Clinical Documentation – Please submit a Letter of Medical Necessity (LOMN) which includes the following:
Diagnosis
Procedure/CPT code
Reason for continued service
Site of service
Name and credentials of servicing provider
Area to be treated
Expected number of treatments
Description of what the skin graft will be used for

Please verify the procedure being requested is the following:	
Electrolysis or laser hair removal performed by a licensed provider for the removal of hair on skin being used for genital gender affirmation surgery.	❒

Physician's signature: _____

The above requested information is required for the claim to process.
Failure to submit this information in full may result in prior authorization denial or incomplete claims processing.