



MASSACHUSETTS

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

Request for Assisted Reproductive Technology Services

BCBSMA Members, please fax to 1-800-836-1112

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 that is expected to render them infertile

Member undergoing treatment other than Chemotherapy 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

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

Biological female with a known cause of infertility

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): _____

IUI to IVF conversion

IVF IVF Freeze all IVF/FET (≤34yrs) Frozen Embryo Transfer (FET) # of frozen eggs/embryos remaining _____

Donor Egg /Embryo Assisted hatching ICSI

Donor sperm

MESA TESE Sperm Cryopreservation

PGD: specific genetic dx: _____ PGS

Early Pregnancy Monitoring (EPM)

Reciprocal IVF (Covered only if specified in the member's subscriber certificate/rider)

Any other pertinent clinical information: _____

Diagnostic Tests required: Please attach copies

HSG/Laparoscopy/Hysteroscopy (for IUI) OR Uterine cavity evaluation (sonohysterogram/HSG or Hysteroscopy, yearly 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); Semen Analysis (for ICSI we only accept Kruger Morphology and there must be at least 2 samples, see [medical policy #086](#) for details).