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).