Fax completed form to (614) 292-2667

Gender Reassignment Surgery Authorization Form

Patient Information

Patient Name:
Member ID #:
DOB:

Requesting Provider Information

Physician Name:
Office Contact Name:
Phone #:
Fax #:

Performing Provider Information ☐ **In-Network Provider** ☐ **Out-of-Network Provider**

Provider Name: Contact Name:	TIN: NPI:	
Address:		
City:	State:	Zip:
Phone #:	Fax #:	

Diagnosis [ICD-10 Code(s)]:	Procedure(s) Requested [CPT Code(s)]:

- **Requirements for mastectomy (female-to-male patients):**
  - Single letter of referral from a qualified mental health professional (see Appendix); and
  - Persistent , well-documented gender dysphoria (see Appendix); and
  - Capacity to make a fully informed decision and to consent to treatment; and
  - Age of majority (18 years of age or older); and
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

- **Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):**
  - Two referral letters from qualified mental health professionals, one in a purely evaluative role (see Appendix): and
  - Persistent, well-documented gender dysphoria (see Appendix); and
  - Capacity to make a fully informed decision and to consent for treatment; and
  - Age of majority (18 years of age or older); and
  - If significant medical or mental health concerns are present, they must be reasonably well controlled; and
  - Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication).
    Hormone Therapy: ____________________
    Date(s) of Hormone Therapy: ____________________
    Medical Contraindication (if applicable):____________________

- **Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female-to-male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male-to-female):**
  - Two referral letters from qualified mental health professionals, one in a purely evaluative role (see Appendix); and
  - Persistent, well-documented gender dysphoria (see Appendix); and
  - Capacity to make a fully informed decision and to consent for treatment; and
  - Age of majority (18 years of age or older); and
  - If significant medical or mental health concerns are present, they must be reasonably well controlled; and
  - Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication)
    Hormone Therapy: ____________________
    Date(s) of Hormone Therapy: ____________________
    Medical Contraindication (if applicable): ____________________
  - Twelve months of living in a gender role that is congruent with their gender identity (real life experience)

- **Appendix:**

  - **Characteristics of a Qualified Mental Health Professional:**
    - Master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board. The professional should also have documented credentials from the relevant licensing board or equivalent; and
    - Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes; and
    - Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; and
    - Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; and

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- Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

- **Format for referral letters from Qualified Health Professional:**
  - Client's general identifying characteristics; and
  - Results of the client's psychosocial assessment, including any diagnoses; and
  - The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date; and
  - An explanation that the WPATH criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery; and
  - A statement about the fact that informed consent has been obtained from the patient; and

  Note: When two letters are required, the second referral is intended to be an evaluative consultation, not a representation of an ongoing long-term therapeutic relationship, and can be written by a medical practitioner of sufficient experience with gender dysphoria.

- **DSM 5 Criteria for Gender Dysphoria in Adults and Adolescents:**
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two or more of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
    - A strong desire for the primary and/or secondary sex characteristics of the other gender
    - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
    - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
    - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
  - The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

PLEASE INCLUDE ALL NECESSARY DOCUMENTATION WITH THIS FORM

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic. This list is not all-inclusive.

Requesting Physician Signature: ______________________________ **Date:** ______________

The form should be completed by the clinician who has a thorough knowledge of the member's current clinical presentation and his/her treatment history. Please complete all parts as clearly and specifically as possible. Omissions, generalities and illegibility will result in the form being returned for completion or clarification.

For questions, please contact The OSU Health Plan at 614-292-4700.

HEALTH PLAN USE ONLY:

Authorization #:	**Date Span:**
Approved by:	**Phone #:**
Comments:	

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