

OSU Health Plan Infertility Authorization

Email completed form with supporting documents to: UtilizationManagement.OSUHealthPlan@osumc.edu
or Fax to: 614-292-2667

Member must meet the definition of infertility as stated below:

Infertility is the condition of an individual who has been unable to conceive or produce conception during a period of one year up to the age of 35 and 6 months if over the age of 35. Infertility can arise in both men and women. A woman is considered infertile if she is unable to conceive or produce conception after the stated period of frequent, unprotected heterosexual intercourse with a fertile male. A woman without a male partner may be considered infertile if she is unable to conceive after at least twelve cycles of donor insemination if under 35 and 6 if over 35. A woman must be pre-menopausal or experiencing menopause at a premature age, before the age of 43, and reasonably expect fertility as a natural state.

Member Information:

Member's Name: _____ Member's Health Plan ID#: _____

Treating Physician: _____ Date of initial visit: _____

Member's Age: ____ DOB: _____ Date of onset of LMP: _____

Date of member's last used contraception: _____ Type: _____

Male/Female history of sterilization (date and procedure/treatment): _____

Type of infertility: _____ ICD-10-CM Code(s): _____

Type of treatment recommended: _____ CPT Code(s): _____

The following documents must be submitted with this form:

- Progress notes documenting infertility as defined in the OSU Health Plan Infertility Treatment Policy.
- Sperm counts, ultrasounds and other supportive documentation when applicable to the case.
- Referral to High Risk OB / Maternal Fetal Medicine with initial authorization request request members with morbid obesity (BMI= \geq 40).

Provider Information:

Printed Name of OB/GYN or Reproductive Endocrinologist: _____

Signature of OB/GYN or Reproductive Endocrinologist: _____

OB/GYN or Reproductive Endocrinologist Phone #: _____ Fax #: _____

My office or Facility uses current American Society of Reproductive Medicine standards

To be completed by OSU Health Plan

Authorization #: _____ Authorization period: _____ Lifetime maximum: _____

OSU Health Plan contact: _____ Contact phone#: _____

NOTICE: This message is intended for the use of the individual(s) to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify the sender immediately and delete the related message.