THE OHIO STATE UNIVERSITY
HEALTH PLAN

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 members with morbid obesity (BMI=/>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

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To be completed by OSU Health Plan

Authorization #: _____Authorization period: _____ Lifetime maximum: _____

OSU Health Plan contact: _____ Contact phone#: _____