THE OHIO STATE UNIVERSITY
HEALTH PLAN

Gender-Affirmation Surgery Authorization Form

Email completed form to: UtilizationManagement.OSUHealthPlan@osumc.edu or fax to 614-292-2667

Patient Information

Patient Name:
Member ID Number:
DOB:

Requesting Provider Information

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

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

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

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

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

Documentation requirements:

- □ 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.
- □ Social transition in place or judged by clinician to be unnecessary (e.g., nonbinary gender identity)
- □ A minimum of 6 continuous months of hormone therapy if required for the patient's gender goals (unless contraindicated)
  - Hormone Therapy: _____
  - Date(s) of Hormone Therapy: _____
  - Medical Contraindication (if applicable): _____

❖ **Appendix:**

Qualifications of Mental Health Professional for assessing transgender and gender diverse adults for physical treatments (from WPATH SOC-8):

- Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.
- Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Are able to assess capacity to consent for treatment.
- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.
- Liaise with professionals from different disciplines within the field of transgender health for consultation and referral on behalf of gender diverse adults seeking gender-affirming treatment, if required.

Credentials of surgeons who perform gender-affirming surgical procedures (from WPATH SOC-8):

- Training and documented supervision in gender-affirming procedures.
- Maintenance of an active practice in gender-affirming surgical procedures.
- Knowledge about gender diverse identities and expressions.
- Continuing education in the field of gender-affirmation surgery.
- Tracking of surgical outcomes.

Format for referral letters from Qualified Mental 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

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: Face-lifting, lip enhancement, facial bone reduction, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), skin resurfacing, chin implants, nose implants, and lip reduction are excluded from coverage. 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

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