THE OHIO STATE UNIVERSITY
HEALTH PLAN

OSU Health Plan Infertility Request Form

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

Patient Information	
Name of Covered Person (Patient):	Health Plan ID:
Date of Birth:	Assigned Gender at Birth:
Identified Gender:	If this is an extension, please provide previous authorization number:
Provider Information	
Name of Treating Provider:	Adress:
TIN:	Contact Name:
Phone Number:	Fax Number:
Clinical History	
Date of Initial Visit:	Date of LMP:
Type of Contraception and Dates Utilized:	
Does the Covered Person currently have a partner? ☐ Yes ☐ No	Is the partner ☐ Male ☐ Female Partner's Full Name:
Is the Covered Person currently trying to conceive with their current partner? ☐ Yes ☐ No	If yes, how long has the Covered Person been trying to conceive with this partner?
Is there a history of sterilization for the Covered Person? ☐ Yes ☐ No	If yes, type of procedure and date:
Is there a history of sterilization for the partner? ☐ Yes ☐ No	If yes, type of procedure and date:
Is there a history of fertility treatment? ☐ Yes ☐ No	
If yes, please provide the date, type of procedure, and outcome:	
If Covered Person is currently undergoing active treatment, please provide the following: Date of last cycle: Last dose of medication (e.g., clomid, letrozole, Gonal-F, etc.): Date of next planned cycle:	
Billing Information	
ICD-10 Code(s):	
Treatment recommended:	

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 for members with morbid obesity (BMI=/>40).
- ☐ Unmedicated day 3 FSH level within the past 12 months.