HIGHMARK DELAWARE

REQUEST FOR IVF COVERAGE

Physician's name and address:

Current date: _____

Patient's name: _____

Highmark BCBS DE ID #: _____

Please fax completed form and any supporting clinical documentation and/or information to the Medical Management and Policy Department for Prior Authorization of In Vitro Fertilization(IVF):

Fax: 800.670.4862 (Delaware) or 888.236.6321

For **In Vitro Fertilization**, please complete the following questionnaire and forward to Claims Review for an IVF coverage determination.

BRIEF PATIENT HISTORY:
INFERTILITY WORK-UP AND TREATMENT/MEDICATIONS/SURGERY/TO DATE - LIST TESTS AND RESULTS:
PLEASE SPECIFY THE CAUSE OF INFERTILITY:
PROPOSED TREATMENT:

Has the patient had a tubal ligation? ..... ❑ Yes ❑ No

Has spouse had a vasectomy? ..... ❑ Yes ❑ No

Are you a Blue Cross Blue Shield participating provider? ..... ❑ Yes ❑ No

Blue Cross Blue Shield Provider ID # : _____

Signature: _____

Person's Name completing this form: _____

Office phone number: ( ) _____