# Infertility services prior authorization request form

Servicing infertility specialist and facility: _____

Requested service(s) and codes: _____

**Please complete the following information:**

| | Patient | Partner |
|---|---|---|
| **Full name** | | |
| **Date of birth** | | |
| **Fallon Health member number** | | n/a |
| **Diagnosis** | | |
| **Length of time trying to conceive** | | n/a |
| **History of voluntary sterilization?** | | |

| Test or procedure | Date completed | Results |
|---|---|---|
| HSG/hysteroscopy, laparoscopy | | |
| Day 3 FSH and E2 within the last 12 months | | |
| List all previous treatments (IUI, IVF or donor egg), including dates | | |
| List outcome (e.g. live birth, ectopic, miscarriage, D&E) and dates of all previous pregnancies | | |
| Semen analysis | | |
| Current substance abuse (Smoking, ETOH, etc.) for the member and partner | | |
| BMI | | |

Please attach all infertility consultation notes as well as ART summary sheets and clinical notes for any previous ART cycles.

Form completed by (please print): _____

Referring physician: _____

Fax completed form to the Fallon Health Infertility Coordinator at 1-508-368-9700.

For questions, please call 1-508-368-9928 or 1-508-368-9138.