WHC
WOMEN'S HEALTH CONSULTANTS
Providing Hope • Fulfilling Dreams

Insurance Verification Form

Please complete this insurance verification form prior to your initial consultation with the doctor. Use this form as a questionnaire when calling the member services phone number on your insurance card.

It is *your responsibility* to call your insurance company to review your fertility benefit. Once you have this information, it is your responsibility to inform office staff of benefit information and/or change of insurance. Those with no fertility coverage or those with High Deductible Plans (>$1000) must call the office prior to their consultation to discuss pricing.

□ Patient Information:

Patient Name: _____ Patient DOB _____

Relationship Status: Single / Female-Female/ Female-Male

Partner Name (If Applicable): _____ Partner DOB _____

Address: _____

_____

Phone: _____

Email: _____

□ Insurance Information:

Provider: _____ Effective Date: _____

ID Number: _____ Group: _____

Type of Policy: HMO PPO POS PHO

- If HMO, Referring PCP: _____ Referral Obtained:_____

In-Network Benefit Coverage: _____ Out of Network: _____

Yearly Deductible: _____ Amount Met: _____ Out of Pocket: _____

Specialist Copay: _____

Claims Address: _____

Type of Coverage:

□ *Fertility Benefit vs. Infertility Benefit*

- Are there any exclusions?
  - Single Female
  - Same-Sex Couple
  - Previous Tubal Ligation
  - Previous Vasectomy
  - Length of Attempted Conception Requirement
  - Recurrent Pregnancy Loss – Number of miscarriages

□ *Diagnostic*: (Fertility Testing: Z31.41) _____

- Office Visits/Ultrasounds _____
- Bloodwork ____

□ *Treatment*:

Female Infertility (N97.9) ___

Other Procreative Management (Z31.89)____

Assisted Reproductive Technology Procedure: Z31.83)

- Office Visits/Ultrasounds _____
- Bloodwork _____
- Insemination (58322)_____
- In-Vitro Fertilization (58970, 76830, 58974, 76705) _____
- GIFT/ZIFT _____

□ *Fertility Preservation* (Z31.84 +/- Cancer Code – Cancer Code required?) _____

- Consultation _____
- Office Visits/Ultrasounds _____
- Bloodwork _____
- Trans-Vaginal Aspiration of Oocytes _____

□ *Donor Egg Coverage*

Anonymous Oocyte Donor <35(Z52.810

Designated Oocyte Donor <35 (Z52.811)

Designated Oocyte Donor >35 (Z52.813)

- Office Visits/Ultrasounds: _____
- Bloodwork (at WHC): _____
- Transvaginal-Aspiration of Oocytes: _____
- Embryo Transfer to Intended Parent: _____

□ *Gestational Carrier Coverage*

Assisted Reproductive Technology Procedure(Z31.83)

Encounter for Procreative Management/Counseling for GC (Z31.7)

Encounter for Procreative Management (Z31.9)

- Office Visits/Ultrasounds :_____
- Bloodwork (at WHC): _____
- Embryo Transfer (58974,76705): _____

□ *Medication*:

- Injectable Medication Coverage: _____
    - Specialty Pharmacy Information
        - Name: _____
        - Phone: _____

□ *Pre-Certification*:

- Required Prior to treatment: _____
    - If yes, Pre-Cert Information:
        - Phone: _____
        - Fax: _____

Verification Date: _____

Insurance Number: _____

Benefits Specialist Name: _____ Reference Number: _____