

Assisted Reproductive Technologies Insurance Verification Worksheet

The following is a personal plan worksheet that you may use when contacting your insurance carrier. Contacting your insurance carrier by phone to obtain benefit information is helpful but it is always a good idea to also obtain your benefits in writing prior to beginning a treatment cycle.

Most insurance companies will not commit to paying for a procedure before a claim has been filed, but they may confirm if certain procedures are covered under your policy and at what percentage those procedures will be paid.

To obtain written verification, call your insurance carrier and request the address and the name of a person to whom you may send your “predetermination for benefits request”. Be very specific in your letter, which should include your situation and the treatment program specific CPT codes. The CPT codes (or billing codes) are included on the price list in your packet. A copy of this price list is often sufficient information for the insurance carrier.

When you contact your carrier:

Verify if you have the following services covered: Diagnostic testing for infertility, injectable infertility drugs, artificial insemination, in vitro fertilization, and/or surgeries to correct or restore fertility (depending on your individual situation).

If the carrier states that infertility drugs and monitoring are covered, verify that you still have the benefit if your treatment includes artificial insemination or IVF. Sometimes, insurance companies will only cover medications and monitoring if they are **not** used in conjunction with “artificial means of conception.” However, it is possible that the carrier will cover medications and monitoring but not the actual insemination. Always be very specific in your request.

If you have coverage for artificial insemination or IVF, verify what the benefit includes. Does your benefit include a lifetime maximum, and if so, what is that maximum? Does the maximum include past services rendered with previous insurance companies? Ask your carrier if drugs are included in the benefit amount or if there is a separate benefit for drugs.

Verify if there are certain criteria that need to be met before starting treatment. Often carriers require that one meet certain criteria such as providing a letter of medical necessity, verifying length of time attempting conception, or length of employment before the benefit is effective.

There are many different types of health insurance and many variables within each type of plan. Most people are covered by group insurance through their employers. Most employers offer a choice of several different plans to their employees. Employees should investigate the benefits of each health plan being offered before selecting one. When an

employer contracts with an insurance carrier for their employees, they negotiate or purchase policies that provide specifically requested benefits, such as infertility benefits.

Procedure and diagnosis coding for infertility treatment can easily be mistaken for diagnostic testing when the billing is filed. Please remember that your insurance company may request access to your medical records and we are required to code according to the treatment you receive.

Please do not request that we falsify claims or diagnoses codes for you to obtain benefits you do not have. Many times insurance companies will pay in error leading to a patient believing they have coverage, even though the benefit for infertility does not exist. Office visits, labs, and ultrasounds are sometimes paid by an insurance carrier without the carrier realizing the services are treatment related (rather than for diagnosis). Usually, if paid in error, within a few months the error is corrected and the payments returned. You would then be billed for these services.

Worksheet

Insurance Company Name:

Insurance Phone Number:

Insurance address:

Contact Name:

My Insurance ID #:

Questions to Ask:

Do I have coverage for diagnostic testing for infertility?

Do I have coverage for treatment for infertility?

Do I need a referral or prior authorization from my primary care physician before visiting my reproductive endocrinologist?

Do I have a lifetime maximum benefit for infertility treatment? Does this maximum include medications?

**Do I have coverage for infertility drugs (Clomid, Follistim, Repronex, Pergonal...)?
If so, do I need prior authorization for these drugs?
If prior authorization is required, how and by whom is this accomplished?**

Are there specific pharmacies that participate with my plan?

Do I have a lifetime maximum benefit for infertility drugs?

**Does my plan exclude coverage for artificial insemination (WIUI)?
If not excluded, do I need separate prior authorization for this procedure?**

**Does my plan exclude coverage for In Vitro Fertilization?
If not excluded, do I need prior authorization for IVF?**