EmblemHealth® | UnitedHealthcare®

Infertility Request Form

Required information

From _____   Phone _____

Reference number _____   Pages (including cover) _____

Comments _____

Please upload the completed form below or required clinical information to the NYCE PPO portal at **nyceppo.com** to assist in a timely determination of coverage. An accurate decision cannot be made without this information.

UnitedHealthcare Commercial Medical & Drug Policies

Required clinical information

Patient name _____   Patient date of birth _____
                                                                    MM/DD/YYYY

Primary infertility diagnosis _____

Number of months trying to conceive (select appropriate)   Greater than 1 year   Less than 1 year

Gravida   Para   Term   Preterm   Abortions   Live births

Infertility treatment being rquested (please select):

IUI   PGT-SR   FET   Gestational carrier

eSET   IVF   PGT-A   PGT-M

Ovulation induction   Egg donation   ICSI   PGD

Other _____

Previous treatments (please indicate number of past treatments/cycles for those that apply):

Ovulation induction _____   IUI _____

IVF _____   ICSI _____

FET _____

(Continued)

Required clinical information (continued)

Labs and diagnostic testing

HSG: (select result if patient has had one done)   Normal   Abnormal

Most recent labs: FSH   AMH   AFC

Semen analysis

Date (MM/DD/YYYY)			
Motility			
Volume			
Morphology			
Count			

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