UHA HEALTH INSURANCE
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PRIOR AUTHORIZATION REQUEST FOR ARTIFICIAL INSEMINATION/ INTRAUTERINE INSEMINATION

Please send completed form to UHA Health Care Services via fax at 866-572-4384 or via mail to UHA, Health Care Services Department, 700 Bishop Street, Suite 300, Honolulu, HI 96813. For telephone inquiries, call 808-532-4006, or 800-458-4600, extension 300, from the neighbor islands.

I. Member Information:

Patient Name:	Patient Member Number:	Date of Birth: (MM/DD/YYYY)
Patient Gender ☐ Male ☐ Female	Phone Number:	UHA Plan: ☐ 600 ☐ 3000
Subscriber Name:	UHA Group Number:	Other:
Other Insurance? ☐ Yes ☐ No	Specify Other Insurance:	Subscriber:

II. Provider Information:

Requesting Provider:	Phone:	
Contact Person:	Fax:	
Address/Phone:	Requested Facility w/TIN:	
Personal Physician:	Phone:	Fax:
Procedure requested:	CPT Code:	
Diagnosis:	ICD Code:	
Date of Service:		

Check and complete all that are applicable:

Applicable ICD-10 diagnosis code: ☐Z31.81 ☐Z31.83 ☐Z31.84 ☐Z31.89 ☐_____

☐ Previous in vitro fertilization, insurance carrier: _____

Date of procedure:_____Physician name:_____Facility name: _____

Are donor eggs (oocytes) being used: ☐Yes ☐No Is sperm from patient's partner: ☐Yes ☐No

☐ The couple has a_____- year history of infertility, or infertility associated with one or more of the following conditions:

- ☐ Endometriosis
  (Provide documentation of diagnosis and past treatment for endometriosis)
- ☐ Exposure in utero to diethylstilbestrol (DES)
- ☐ Blockage or surgical removal of one or more fallopian tubes
- ☐ Abnormal male factor contributing to the infertility
- ☐ (Provide 2 semen analyses performed ≥ 2 weeks apart)

Please submit supporting documentation.
List all physicians that can verify the conditions listed:

Previous IUI Date:_____ (with Gonadotropin Y/N) _____

Previous IUI Date:_____ (with Gonadotropin Y/N) _____

Previous IUI Date:_____ (with Gonadotropin Y/N) _____

☐ The patient and partner have been unable to attain a successful pregnancy through other infertility treatments for which coverage is available.

Date:_____Provider:_____Type of treatment: _____

Date:_____Provider:_____Type of treatment: _____

☐ Patient is aged 44 years or older. Date of patient's last menstrual period: _____

Labs: Day 3 FSH _____

Day 3 Estradiol _____

Antral Follicle Count (AFC) Date:_____Result: _____

Anti-Mullerian Hormone (AMH) Date:_____Result: _____

Drug Name:

☐ Follistim AQ Total units requested: _____

☐ Gonal-F Total units requested: _____

☐ Patient has been pregnant in the past. Please provide detailed past obstetrical history.

OB History Table

Year	Outcome	Gestational Age
	Live birth Miscarriage	
	Live birth Miscarriage	
	Live birth Miscarriage	
	Live birth Miscarriage	

☐ Has either partner been sterilized? Yes_____No____OR Has either partner had a sterilization reversal? Yes_____No_____

SUBMIT THIS SIGNED AND COMPLETED FORM ALONG WITH SUPPORTING CLINICAL DOCUMENTATION

Physician Acknowledgment:
I have read and understand the definition of medical necessity outlined in Hawaii Revised Statutes 432E-1.4. (see back of sheet). I further understand that UHA applies this definition to the authorization and payment for all services rendered to its members. I, or my agent acting on my behalf, attest that the services requested above meet the definition of medical necessity

_____ _____

Signature of Physician or Agent **REQUIRED** Date