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Infertility Coverage Worksheet

NAME: _____ **DOB:** _____

Insurance Co: _____ **ID#:** _____

Insurance Phone: _____ **Group #:** _____

1. Do I have coverage for the diagnosis of, or investigation of, infertility? _____

2. Amount of coverage? _____ Full _____ % of coverage

~ What is my out-of-pocket expense? _____

3. Do infertility services need pre-authorization? _____

~ For each visit? _____

~ If not, what type of visit(s) need to be preauthorized? _____

4. Do I need a referral from my Primary Care Physician? _____

5. Person I spoke with today? _____

Are the following items covered under my infertility coverage?

- | | | |
|---------------------------------|---|---|
| 1. Blood testing | Y | N |
| 2. Vaginal cultures | Y | N |
| 3. Hysterosalpingogram | Y | N |
| 4. Sonohysterogram | Y | N |
| 5. Post Coital Testing | Y | N |
| 6. Endometrial Biopsy (EMB) | Y | N |
| 7. Laparoscopy | Y | N |
| 8. Semen Analysis | Y | N |
| 9. In-Vitro Fertilization (IVF) | Y | N |
| 10. Clomid | Y | N |
| 11. Hormone Injections | Y | N |

Patient's Signature: _____

DATE: _____

