ASSISTED REPRODUCTIVE TECHNOLOGY (ART) BENEFIT

PHYSICIAN VERIFICATION and PROOF OF PAYMENT

Instructions: FAX completed form to **PEHP Clinical Services at 801-366-7449 (FAX)** or mail to: 560 East 200 South Salt Lake City, UT 84102.

SUBMIT THIS FORM AFTER PROCEDURE HAS BEEN PERFORMED. ATTACH PROOF OF PAYMENT (RECEIPT).

For benefit questions, please call 801-366-7755 or 800-753-7754.

Section I: PATIENT INFORMATION

PEHP Subscriber Name: ______________________________ Subscriber DOB: ____________
(Last name, First, Middle)

PEHP Subscriber ID #: ____________________ Spouse Name: ____________________ Spouse DOB: ______________

Address: ____ Phone: ____________________________

To be Completed by the Physician

Section II: PHYSICIAN / PROVIDER INFORMATION

Date of Verification: ______________ Physician Name: ____

Facility Name and Address: ____

Contact Name: ____________________ Phone #: ____________________ Fax #: ____________________

Service Provider Address: ____

Section III: PROVIDER VERIFICATION

Is there a demonstrated condition recognized by a physician as a cause of infertility?

PEHP Subscriber Name: ___________________________ **YES** **NO** *(check one)*

Diagnosis/ICD-10 Code: ______________

Spouse name: ___________________________________ **YES** **NO** *(check one)*

Diagnosis/ICD-10 Code: ______________

Date of ART Service: ___________ **ART Procedure:** ***(check all that apply)***

_____ **IVF (may include ICSI, FET)**
_____ **GIFT**
_____ **ZIFT / TET / PROUST**
_____ **Specialized sperm retrieval (i.e., MESA / PESA / TESA / TESE / TEFNA / Other)**

***Internal Use*: Forward to Clinical Services**