Gender Reassignment Surgery Authorization

Purpose of this form

You can use this form to initiate your pre-authorization request. The form will also help you know what supporting documentation is needed for GEHA to review your request.

How to complete the form

We recommend reviewing GEHA's coverage policy for surgical treatment of gender dysphoria before completing this form. You can find this coverage policy within the provider section at geha.com. This will allow you to view the criteria used to determine medical necessity and procedures that are allowable.

For us to review your request properly and to avoid delay, you must complete all sections of the form and provide the necessary supporting documentation. If you have questions about the form or need assistance, you can speak with a surgical specialist at 800.821.6136, ext. 3100.

After you have completed the form

You will fax this completed form along with supporting documentation to GEHA's Medical Management department at 816.257.3255. If photos are necessary, they may be emailed to caremanagementsurgery@geha.com.

If unable to fax, please mail pre-authorization request to:

GEHA
P.O. Box 21542
Eagan MN 55121

*If the patient lives in Texas, call United Healthcare Choice Plus at 877.585.9643.

Our preservice reviews are completed within 15 days from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the normal time for an authorization could seriously jeopardize a patient's life, health or ability to regain maximum function.

This authorization determines the medical necessity of services requested based upon the information provided. It is NOT a guarantee of payment. It is issued subject to the terms and limitations of your agreement and the member's benefit plan, and subject to the member being eligible at the time services are provided. We reserve the right to deny reimbursement in the event of fraud or misrepresentation or if there is a material change in facts and circumstances that varies from the information that was provided with the original request.

Then information contained in this form is confidential and only intended for the use of individuals and or entity named above.

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Patient information

Date of request: ______________________ Patient phone: ______________________

Patient name: ______________________ [First name] ________ [Middle initial] ______________________ [Last name]

Patient ID number: ______________________________ Date of birth: ______________________

Member name: ______________________ [First name] ________ [Middle initial] ______________________ [Last name]

Member address: ____

____

Member's relationship to patient? ☐ Self ☐ Spouse ☐ Dependent

Is there other coverage? ☐ Yes ☐ No

If yes, what is the name of the other insurance carrier? ______________________________

Anticipated surgery date: ____________________

Physician information

Name: ______________________ [First name] ________ [Middle initial] ______________________ [Last name]

Tax ID number: ______________________

Office street address: ____

City: ______________________ State: _______________ Zip: __________

Contact person: ______________________ [First name] ________ [Middle initial] ______________________ [Last name]

Phone number: ______________________ Fax: ______________________

Facility information

Name: ____

Office street address: ____

City: ______________________ State: _______________ Zip: __________

FTIN: ______________________ NPI: ______________________

Requested procedure(s) CPT: __________ __________ __________ __________ __________ __________

Primary diagnosis ICD-10: _______________ ICD-10 codes: __________ __________ __________