



The Benefits of Better Health

### Gender Reassignment Surgery Authorization

**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? \_\_\_\_\_

**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: \_\_\_\_\_

**Facility information**

Name: \_\_\_\_\_

Office street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

FTIN: \_\_\_\_\_ NPI: \_\_\_\_\_

Requested procedure(s) CPT: \_\_\_\_\_

Primary diagnosis ICD-10: \_\_\_\_\_ ICD-10 codes: \_\_\_\_\_



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### **Clinical information required for review**

- Prior authorization is required.
- Member or patient is 18 years of age or older.
- There is evidence of persistent gender dysphoria documented.
- 12 months or more of continuous hormone therapy as appropriate to the member/patient's gender goal is required before surgery for gender dysphoria.
- Two letters of referral from qualified mental health professionals are required for genital reconstructive surgery (e.g., vaginectomy, urethroplasty, phalloplasty, scrotoplasty, penectomy, vaginoplasty, labiaplasty and clitoroplasty).
- Surgery to change specified secondary sexual characteristics such as bilateral mastectomy requires a letter from a qualified mental health professional; a trial of hormone therapy is not a prerequisite.
- Augmentation mammoplasty is covered only if there is inadequate breast enlargement after undergoing hormone treatment for at least 18 months and is not sufficient for comfort in the social role.
- Any significant medical or mental health concerns are reasonably well controlled.
- One sex assignment surgery per lifetime.
- Patient has to have capacity to make decisions.
- Only one transgender surgical event per lifetime.
- Surgery must be done in the United States.

**Please fax completed form and supporting documentation to 816.257.3255**

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

GEHA  
P.O. Box 4665  
Independence, MO 64051

Questions? Call GEHA at 800.821.6136 ext. 3100

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.