Gender Affirmation Surgery Authorization

Refer to the back of the patient's ID card under the heading *Prior Authorization* for the appropriate contact information.

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 Gender Affirmation Surgery** before completing this form. You can find our coverage policies at **Provider resources**. These will allow you to see the criteria used to determine medical necessity and procedures that are not 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 help, 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

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.

GEHA

Gender Affirmation Surgery Authorization Form

Refer to the back of the patient's ID card under the heading *Prior Authorization* for the appropriate contact information.

Date of request: _____ Anticipated service date: _____

Patient name: _____ Phone: _____

Preferred pronouns: _____ (optional)

ID number: _____ Date of birth: _____

Member address: _____

_____

Physician: _____

Tax ID: _____

Address: _____

_____

Contact: _____

Phone: _____ Ext. _____ Fax: _____

Facility: _____

Tax ID: _____

Address: _____

_____

Contact: _____

Phone: _____ Ext. _____ Fax: _____

DX: _____ ICD-10 code: _____

Requested procedure(s) CPT: _____ _____ _____ _____ _____

Place of service: ☐ Inpatient ☐ Outpatient

Note: Inpatient stays require a separate authorization from the surgery.

Submit completed form and supporting documents to:

GEHA
P.O. Box 21542
Eagan, MN 55121

Fax: 816.257.3255 or
Color photos to secure email:
caremanagementsurgery@geha.com

Questions: Call GEHA at 800.821.6136, ext. 3100

All benefit payments are subject to review for any applicable deductibles, coinsurance, maximums, medical necessity, and patient eligibility on the date that the service is provided, or the supply delivered.