Letter Requesting Predetermination of Drug Coverage

[Date]

[Your insurance company name/pharmacy benefit manager name and address]

RE: Predetermination of benefits for: [patient's name]
Group/Group Number: [name of group, if applicable]
ID Number: [patient's insurance identification number]

Dear [Insurance company contact name]:

My [husband, wife, partner] and I are considering infertility treatment. This procedure is necessary to attempt pregnancy due to [explain your situation, e.g. blocked fallopian tubes, male factor, previous sterilization, unexplained infertility, etc.]. Please provide me with a written response to each of the questions below:

- Is there a pre-existing condition limitation?
- Are separate referrals required for office visits, treatments cycles, medications and surgical procedures?
- Which medications are covered by my medical plan?
    - For ovulation induction (OI)?
    - For intrauterine insemination (IUI)
    - For in vitro fertilization (IVF)?
    - For gamete intrafallopian transfer (GIFT)?
    - For zygote intrafallopian transfer (ZIFT)?
    - For artificial insemination (AI)?
    - For embryo transfer (ET)?
- If covered under a pharmacy benefit, what is the co-payment or deductible?
- Is coverage dependent upon the use of certain pharmacies?
- Is there a limit of any kind (dollars, time period, or number of cycles)?
- If yes, are they lifetime limits or annual limits?
- If none of the charges are payable, please identify the page in my contract where all charges are specifically excluded and the date the exclusion was added to the contract. If the charges are not excluded, I will assume they are payable.

I would appreciate a written response as soon as possible. Thank you. If you have any questions, please call [your phone number].

Sincerely,
[your name and address]

Letter Requesting Predetermination of Benefits

[Date]

[Your insurance company name and address]

RE: Predetermination of benefits for: [patient's name]
Group/Group Number: [name of group, if applicable]
ID Number: [patient's insurance identification number]

Dear [Insurance company contact name]:

My [husband, wife, partner] and I are considering [in vitro fertilization (IVF), Intra-cytoplasmic sperm injection (ICSI), egg or embryo cryopreservation or other procedure your doctor has recommended]. This procedure is necessary to attempt pregnancy due to [explain your situation, e.g. blocked fallopian tubes, male factor, previous sterilization, unexplained infertility, etc.]. A fee schedule from our physician is attached for your review.

Please provide me with a written response to each of the questions below:

- Is there a pre-existing condition limitation?
- Are separate referrals required for office visits, treatments cycles, medications, and surgical procedures?
- Will [the procedure that applies to your situation] be a payable procedure under my current coverage or under my major medical portion?
- If yes, is there a limit of any kind (dollars or number of attempts)?
- If no, are any portions of the charges payable (prescription medications, laboratory tests, ultrasounds, or any other components my doctor has identified)?
- To what extent does the plan cover support services, such as psychological counseling?
- If none of the charges are payable, please identify the page in my contract where all charges are specifically excluded and the date the exclusion was added to the contract. If the charges are not excluded, I will assume they are payable.

I would appreciate a written response as soon as possible. Thank you. If you have any questions, please call [your phone number].

Sincerely,
[your name and address]