BlueCross BlueShield of Tennessee Gender Reassignment Surgery Precertification Request Form

The BCBST Medical Policy for Gender Reassignment Surgery can be found at https://www.bcbst.com/mpmanual/Gender_Reassignment.htm

PLEASE FAX THIS COMPLETED FORM TO: 1-866-558-0789
OR MAIL TO: BlueCross BlueShield of Tennessee
Commercial Utilization Management
Suite 0045
1 Cameron Hill Circle,
Chattanooga, TN 37402-0017

*** See BlueCross BlueShield of Tennessee medical policy for Gender Reassignment for details. ***

Date: ________________

Member Name: ______________________ DOB: _____________ BCBSTN ID#: ______________________

Member telephone: (home) ______________________ (work) ______________________ (cell) ______________________

Procedure(s) being requested: CPT code: __________________ and ICD-10 diagnosis code(s): ________________

Select one:

_____ Female to male gender reassignment  _____ Male to female gender reassignment

Tentative date of surgery: ________________ Type of admission (outpatient, 23 hour OBS, inpatient): ________________

Contact’s Name: ______________________ phone # ______________ fax # ______________

Facility: ____________________________ Facility phone: ______________ Facility fax: ______________

Facility Address: _______________________________________________________________________________

Facility NPI # or BlueCross BlueShield of Tennessee Provider #: ______________________________

Mental Health Provider name: ______________________ Office Phone#: ______________________________

Mental Health Provider address: __________________________________________________________________

Mental health credentials: ________________________________________________________________________

Second mental health provider (If required by type of procedure requested)

Mental Health Provider name: ______________________ Office Phone#: ______________________________

Mental Health Provider address: __________________________________________________________________

Mental health credentials: ________________________________________________________________________

Surgeon: ___________________________ Surgeon phone: ______________ Surgeon fax: ______________

Surgeon Address: ______________________________________________________________________________

Surgeon NPI # or BlueCross BlueShield of Tennessee Provider #: ____________________________

SIGNATURE: ______________________ DATE: ________________

This document has been classified as public information.
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Member Name: ______________________________ DOB: _____________ BCBSTN ID#: __________________

General Guidelines:

Individual is 18 years or older   YES _____ NO _____

Individual has the capacity to make a fully informed consent to treatment   YES _____ NO _____

Any significant medical concerns are well controlled (e.g. hypertension, diabetes, coronary artery disease) YES _____ NO _____

Please list any current medical conditions: _______________________________________________________________________

Any significant mental health concerns are well controlled (e.g. anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder)   YES _____ NO _____

Please list any current mental health conditions: ___________________________________________________________________

Documentation shows persistent and well documented gender dysphoria as evidenced by ALL of the following (DSM-V definition):

Select all that apply:

_____ The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

_____ A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by TWO OR MORE of the following:

_____ A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics

_____ A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender

_____ A strong desire for the primary and/or secondary sex characteristics of the other gender

_____ A strong desire to be of the other gender

_____ A strong desire to be treated as the other gender

_____ A strong conviction that one has the typical feelings and reactions of the other gender

Specific procedure requirements (Please include the required clinical documentation):

Female to male gender reassignment:

Mastectomy with nipple/areola reconstruction surgery:
Requires one (1) referral letter from mental health professional with a minimum of a Master’s degree or its equivalent in a clinical behavioral science field (See ADDITIONAL INFORMATION in Medical policy for Letter Criteria)

Hysterectomy and ovariectomy surgery:
Is there documentation of 12 months of continuous hormonal therapy (unless the individual has a medical contraindication or is unable or unwilling to take hormones)? YES_____ NO_____ Contraindication or unable _____ please attach clinical.

Requires two (2) referral letters from mental health professionals with a minimum of a Master’s degree or its equivalent in a clinical behavioral science field. If the first referral is from the patient’s psychotherapist, the second referral should be from the mental health professional that has only had an evaluative role with the patient. (See ADDITIONAL INFORMATION in Medical policy for Letter Criteria)
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Metoidioplasty or phalloplasty surgery:
Is there documentation of 12 months of continuous hormonal therapy (unless the individual has a medical contraindication or is unable or unwilling to take hormones)? YES_____ NO_____ Contraindication or unable _____ please attach clinical.

Does documentation show that the individual has lived continuously for 12 months in a real-life experience, in the gender role that is congruent with their gender identity? YES_____ NO_____ Requires two (2) referral letters from mental health professionals with a minimum of a Master’s degree or its equivalent in a clinical behavioral science field. If the first referral is from the patient’s psychotherapist, the second referral should be from the mental health professional that has only had an evaluative role with the patient. (See ADDITIONAL INFORMATION in the Medical policy for letter criteria)

Male to female gender reassignment:

Breast augmentation with nipple/areola reconstruction surgery:
Requires one (1) referral letter from mental health professional with a minimum of a Master’s degree or its equivalent in a clinical behavioral science field (See ADDITIONAL INFORMATION in the Medical policy for letter criteria)

Is there documentation of 12 months of continuous hormonal therapy (unless the individual has a medical contraindication or is unable or unwilling to take hormones)? YES_____ NO_____ Contraindication or unable _____ please attach clinical.

Orchiectomy; penectomy surgery:
Is there documentation of 12 months of continuous hormonal therapy (unless the individual has a medical contraindication or is unable or unwilling to take hormones)? YES_____ NO_____ Contraindication or unable _____ please attach clinical.

Requires two (2) referral letters from mental health professionals with a minimum of a Master’s degree or its equivalent in a clinical behavioral science field. If the first referral is from the patient’s psychotherapist, the second referral should be from the mental health professional that has only had an evaluative role with the patient. (See ADDITIONAL INFORMATION for in the Medical policy Letter Criteria)

Vaginoplasty surgery:
Is there documentation of 12 months of continuous hormonal therapy (unless the individual has a medical contraindication or is unable or unwilling to take hormones)? YES_____ NO_____ Contraindication or unable _____ please attach clinical.

Does documentation show that the individual has lived continuously for 12 months in a real-life experience, in the gender role that is congruent with their gender identity? YES_____ NO_____ Requires two (2) referral letters from mental health professionals with a minimum of a Master’s degree or its equivalent in a clinical behavioral science field. If the first referral is from the patient’s psychotherapist, the second referral should be from the mental health professional that has only had an evaluative role with the patient. (See ADDITIONAL INFORMATION in the Medical policy for letter criteria)