of Tennessee

Gender Reassignment Surgery Precertification Request Form

See BlueCross BlueShield of Tennessee Medical Policy for Gender Reassignment Surgery details at http://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
1 Cameron Hill Circle, Suite 0045
Chattanooga, TN 37402-0017

Date: _____/_____/_____

Section 1: General Information

Member Name:	DOB:	Member ID#:
Member telephone: (home)	(work)	(cell)
Contact's Name	Phone:	Fax:
Procedure(s) requested:	CPT code:	ICD-10 diagnosis code(s):
Tentative date of surgery: _____/_____/_____ Type of admission (outpatient, 23-hour OBS, inpatient): _____		

Section 2: Provider/Facility Information

Facility:	Phone:	Fax:
Facility Address:		Facility NPI # or Provider ID #:
Mental Health Provider Name:	Phone:	Mental Health Credentials:
Mental Health Provider Address:		

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

Mental Health Provider Name:	Phone:	Mental Health Credentials:
Mental Health Provider Address:		
Surgeon:	Phone:	Fax:
Surgeon Address:		Surgeon NPI # or Provider ID #:

Section 3: Patient Information

Is patient 18 years or older? ☐ YES ☐ NO

Does the patient have the capacity to make a fully informed decision and to consent for treatment? ☐ YES ☐ NO

Does the patient currently have significant medical concerns (e.g. hypertension, diabetes, coronary artery disease)? ☐ YES ☐ NO

If yes, are they well controlled? ☐ YES ☐ NO

Please list any current medical conditions:

Does the patient have significant mental health concerns (e.g. anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders or borderline personality disorder)? ☐ YES ☐ NO

If yes, are they well controlled? ☐ 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

Section 4: Female to Male Gender Reassignment

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

Mastectomy with nipple/areola reconstruction surgery:

Requires one 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:

Do you have documentation of 12 months of continuous hormonal therapy (unless the patient has a medical contraindication or is unable or unwilling to take hormones)? ☐ YES ☐ NO If contraindication or unable, please attach clinical.

Requires two 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 who only had an evaluative role with the patient (see ADDITIONAL INFORMATION in Medical policy for letter criteria).

Metoidioplasty or phalloplasty surgery:

Do you have 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 If contraindication or unable, please attach clinical.

Does documentation show that the patient has lived in the gender role that is consistent with their gender identity (real-life experience) continuously for 12 months? ☐ YES ☐ NO

Requires two 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 who only had an evaluative role with the patient (see ADDITIONAL INFORMATION in the Medical policy for letter criteria).

Section 5: Male to Female Gender Reassignment

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

Breast augmentation with nipple/areola reconstruction surgery:

Requires one 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).

Do you have 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 **If contraindication or unable, please attach clinical.**

Orchiectomy; penectomy surgery:

Do you have 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 **If contraindication or unable, please attach clinical.**

Requires two 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 who only had an evaluative role with the patient (see ADDITIONAL INFORMATION in the Medical policy for letter criteria).

Vaginoplasty surgery:

Do you have 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 **If contraindication or unable, please attach clinical.**

Does the documentation show that the individual has lived continuously for 12 months in a real-life experience, in the gender role that is consistent with their gender identity? ☐ YES ☐ NO

Requires two 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 who only had an evaluative role with the patient (see ADDITIONAL INFORMATION in the Medical policy for letter criteria).

SIGNATURE: _____ Date: _____/_____/_____