of Tennessee

Federal Employee Program (FEP)® and Postal (PSHB)
Gender Affirming Surgery Prior Approval Request Form

See the appropriate Blue Cross and Blue Shield Service Benefit Plan Brochure for Gender Affirming Surgery criteria at
https://www.fepblue.org/plan-brochures

PLEASE FAX THIS COMPLETED FORM TO: 423-591-9091 OR MAIL TO:
BlueCross BlueShield of Tennessee Federal Employee Program®
One Cameron Hill Circle Chattanooga, TN 37402-0017

Date: _____/_____/_____

Section 1: General Information		
Member Name:	DOB: ____/____/____	Member ID#:
Contact's Name:	Phone:	Fax:
CPT code requested:		ICD-10 diagnosis code(s):
Tentative date of surgery: _____/_____/_____ Type of admission (outpatient, 23-hour OBS, inpatient): _____		

Section 2: Provider/Facility Information		
Surgeon:	Phone:	Fax:
Surgeon Address:		Surgeon Provider ID #:
Mental Health Provider		
Mental Health Provider Name:	Phone:	Mental Health Credentials:
Mental Health Provider Address:		

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 medical or mental health concerns present? ☐ YES ☐ NO

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

Please list any current medical
or mental health conditions:

Has the member been diagnosed with gender dysphoria by a qualified healthcare professional with well-documented persistent gender incongruence, including documentation that other possible causes of gender incongruence have been excluded? ☐ YES ☐ NO

The member must meet all the following requirements as indicated in the member's BlueCross and BlueShield Service Benefit Plan Brochure. Supporting documentation should be included with the request.

Select all that apply:

- ☐ A surgical treatment plan that must include timing, technique, duration of aftercare, all surgeries planned, and the estimated date each will be performed. Please note a new Prior Approval should be obtained if the treatment plan is approved and later modified.
- ☐ 6 months of continuous hormone therapy appropriate to the member's gender identity (unless medically contraindicated). **(Not required if only mastectomy is planned)**
- ☐ Written psychological assessment from a qualified mental health professional documenting the diagnosis of persistent gender dysphoria with a well-documented persistent gender incongruence between the assigned gender and the experienced/expressed gender or some alternative gender, support of surgical procedure(s), and well-controlled physical and mental health conditions
- ☐ Documentation of informed consent and fulfillment of the program's criteria for gender affirming surgical treatment.

Please note benefits are not available for repeat or revision procedures unless they are determined to be medically necessary. Benefits are not available for gender affirming surgery for any condition other than gender dysphoria.

Gender affirming surgical benefits are limited to the following:

Breast augmentation, clitoroplasty, electrolysis (hair removal at any covered operative site), facial surgery (limited to Adam's apple enhancement/reduction, botulinum toxin, cheek reshaping, chin reshaping, cosmetic fillers, face lift, fat grafting, forehead reshaping, hair transplant, jaw reshaping, liposuction, and rhinoplasty), voice surgery (pitch lowering or raising surgery/Wendler glottoplasty), hysterectomy, labiaplasty, mastectomy (including nipple reconstruction and suction-assisted chest lipectomy), metoidioplasty, orchiectomy, penectomy, phalloplasty, salpingo-oophorectomy, scrotoplasty, testicular and erectile prosthesis placement, urethroplasty, vaginectomy, vaginoplasty

SIGNATURE: _____ Date: _____/_____/_____

If an inpatient authorization is required, this review does not take the place of that requirement and the inpatient authorization should be requested separately from Utilization Management. If you have any questions, please contact BlueCross BlueShield of Tennessee FEP Customer Service at **1-800-572-1003** or Postal Customer Service at **1-866-780-7742**, Monday through Friday, 8 a.m. to 6 p.m. ET

Please note: Final reimbursement determinations are based on member eligibility at the time of service, Medical Necessity criteria, applicable member copayments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and FEP/PSHB Medical Policy.