Letter Requesting Predetermination of Benefits

[Date]

[Your insurance Company name]

Re: Pre-Determination of benefits for [insert your name]
ID: [insert your insurance identification number]
Group: [insert group name or number]

Dear [insert name]:

My (husband, wife, partner) and I are considering fertility services with Dr. [insert physician name] at Texas Fertility Center. Fertility procedures are 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:

- Do I have infertility benefits under my current insurance plan, for both diagnostic and treatment?
- If treatment of infertility is not covered are any portions of the other charges payable (prescription medications, laboratory tests, ultrasounds, or any other components associated with the excluded procedure)?
- Are there any specific requirements I must meet to qualify for my infertility coverage?
- Is there a pre-existing condition limitation, if so when does it expire?
- Are referrals or prior authorization required for office visits, treatments cycles, medications, and surgical procedures, both outpatient or in office?
- If infertility services are covered are there any specific limitations or maximums (dollars or number of attempts)?
- Is coverage dependent upon the use of certain pharmacies or laboratories?
- 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 listed as excluded, I will assume they are covered and 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 for Medication

[Date]

[Your insurance company name]

Re: Pre-Determination of benefits for [insert your name]
ID: [insert your identification number]
Group: [insert your group name or number]

Dear [insert name]

My (husband, wife, partner) and I are considering fertility services with Dr. [physician name] at Texas Fertility Center. Fertility procedures are 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, if so when does it expire?
- Are referrals or prior authorization required for self-injectable or oral infertility medications?
- If infertility medications are covered are there any specific limitations or maximums?
- Are limitations based on annual or lifetime?
- Which infertility medications are covered under my medical plan?
- For artificial Insemination
- For Intrauterine insemination
- In Vitro Fertilization
- Ovulation Induction
- Is coverage dependent upon the use of certain pharmacies?

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 listed as excluded, I will assume they are covered and 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]