

Date

Insurance Company Name
Street Address
City, State Zip

Re: Predetermination of benefits for (patient's name)

ID number: (patient's insurance identification number)

Group or Group number: (group name or number)

(Find your group and/or ID number and mailing address on your insurance card. This information allows the insurance carrier to locate your group or individual policy and determine benefits).

Dear *Insurance Company*,

I am considering infertility services with Dr. (*physician's name and address*). My partner and I are seeking infertility services due (*explain your situation, e.g., blocked fallopian tubes, male factor, previous sterilization, unexplained infertility, etc.*)

Please provide me with a written response to each question below.

1. Do I have infertility benefits under my current insurance company?
2. Do I have diagnostic infertility coverage allowing the physician to find the cause of my infertility problem?
3. Do I have infertility treatment coverage allowing the physician to perform intrauterine insemination?
4. Do I have infertility treatment coverage for in vitro fertilization? Does this coverage include cryopreservation, intracytoplasmic sperm injection and/or frozen embryo transfer?
5. If yes, does my policy require prior authorization for these procedures?
6. If I have fertility coverage for these procedures, what is my maximum infertility benefit?
7. Does my policy cover injectable medications? If yes, does my policy require prior authorization for injectable medications?
8. Do I need to use a specific laboratory?
9. Do I need a referral to visit Dr. (*physician's name*) for an initial consultation?

I would appreciate a response as soon as possible as I will be seeing my physician in the near future. Thank you.

Sincerely,

(Your signature)