



Gender Affirming Services (Transgender Services) Prior Authorization Request Form #901

Medical Policy #189 Gender Affirming Services (Transgender Services)

BCBSMA Members: 888-282-0780	Medicare Advantage Members: 800-447-2994	BCBSMA Employees: 617-246-4299
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Provider Name: _____	NPI: _____
Facility Name: _____	NPI: _____
Provider Contact Name: _____	Phone: _____
Fax: _____	
Patient Name: _____	Date of Birth: _____
BCBSMA Subscriber Name: _____	ID Number: _____
Date of Service: _____	
Diagnosis Codes: _____	

Anticipated procedures: (check all that apply)	
Mastectomy and/or creation of a male chest for transmasculine/non-binary patients Please list procedure codes being requested:	☐
Breast augmentation for transfeminine patients Please list procedure codes being requested:	☐
Genital surgery for transmasculine, transfeminine or non-binary patients Please list procedure codes being requested:	☐
Facial Feminization or Masculinization Please list procedure codes being requested:	☐
Surgical revision to correct a functional impairment Please list procedure codes being requested:	☐
Other Please state the service being requested and please list the codes:	☐
Please indicate if procedure will be performed: Inpatient ☐ or Outpatient ☐	

Please include supporting clinical documentation for requested procedures.
Inclusion of a code in this table does not imply reimbursement. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts, and Company policies apply.