COMMON GROUND
HEALTHCARE COOPERATIVE

Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630
T: 877.825.9293 | F: 715.221.9749

Transgender Services

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Is member 18 years or older ..... ☐ Yes ☐ No

Has member been referred from two qualified mental health professionals ..... ☐ Yes ☐ No

Does member have persistent gender dysphoria ..... ☐ Yes ☐ No

Is there a mastectomy request for female-to-male patient ..... ☐ Yes ☐ No

Is there a request for gonadectomy (i.e. hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female) ..... ☐ Yes ☐ No

Does member agree to 12 months of continuous hormone therapy as appropriate to the member's gender goals, unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones ..... ☐ Yes ☐ No

Is there a request for genital reconstructive surgery (i.e. vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, placement of a testicular prosthesis and erectile prosthesis in female-to-male; and penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male-to-female) ..... ☐ Yes ☐ No

Does member agree to 12 months of continuous hormone therapy as appropriate to the member's gender goals, unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones ..... ☐ Yes ☐ No

Does member agree to 12 months of living in a gender role that is congruent with their gender identity (real life experience) ..... ☐ Yes ☐ No

Is there a request for gender specific services for the transgender community. . . . . ☐ Yes ☐ No

Is there a request for breast cancer screening . . . . . ☐ Yes ☐ No

Has member undergone a mastectomy . . . . . ☐ Yes ☐ No

Is there a request for prostate cancer screening . . . . . ☐ Yes ☐ No

Has member retained their prostate . . . . . ☐ Yes ☐ No

Is there a request for gonadotropin-releasing hormone to suppress puberty in trans-identified adolescent . . . . . ☐ Yes ☐ No

Has the adolescent demonstrated a long-lasting and intense pattern of gender non-conformity or gender dysphoria (whether suppressed or expressed) . . . . . ☐ Yes ☐ No

Has gender dysphoria emerged or worsened with the onset of puberty . . . . . ☐ Yes ☐ No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. CGHC may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:

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If you have any questions, please contact Customer Service at 1.877.514.2442