NHIF 8d/26

INTRA VITRO FERTILIZATION PRE_AUTHORIZATION FORM

This form is designed to obtain prior authorization for IVF Services as approved by NHIF. All fields relevant to the needed service(s) MUST be completed to inform pre-authorization decision.

- Payments contingent upon validity at the time of service and providers shall be responsible for ascertaining beneficiary eligibility to utilize the IVF benefit package.
- Services not pre-authorized shall not be reimbursed.
- Results of preliminary tests, must accompany this request.
- Referral letter from a specialist must be attached.
- Authorization shall be subject to access guidelines set by NHIF

SECTION 1: PATIENT INFORMATION		
Surname:	Other Names:	
Relationship: Principal Member: ☐ Spouse: ☐ DOB: ☐		NHIF Member No:
Patients ID No:	Member ID No:	Patients Phone No:
Partners Name:	Partners ID No:	DOB:
Year In Marriage: _____		

I certify that the above information is correct and give specific consent for selected IVF services to be done. I undertake to pay any monies not catered for by my medical scheme, subject to scheme rules and necessity of the services. I understand that it is an offence to knowingly make any false statement for purposes of obtaining any benefit under NHIF Act.

Patients' Signature: _____ **Date:**

_____

Partners' Signature: _____ **Date:**

_____

SECTION 2: IVF FACILITY INFORMATION		
Facility Name:	Facility Code:	NHIF Branch:
Attending Gynecologist Name: Signature:	KMPBD No./License No.:	
Attending Embryologist Name: Signature:	KMPBD No./License No.:	
Attending IVF Nurse Name: Signature:	Nursing Council No./License No.:	
Note: You will be required to issue the patient with a care plan for the procedure detailing each phase of treatment		

INDICATION FOR IVF

- ☐ Endometriosis
- ☐ Blockage or surgical removal of one or more fallopian tubes
- ☐ Abnormal male factor contributing to the infertility
- ☐ Others, (Please specify) _____

SECTION 3: TREATMENT DETAILS		
FEMALE TESTS	**SERVICE DATE**	**AMOUNT**
Prolactin		
Thyroid profile		
Antimullerian hormone		
Follical Stimulating Hormone (FSH)		
Luteinizing Hormone (LH)		
TVS(Trans-vaginal ultrasound)		
MALE TESTS	**SERVICE DATE**	**AMOUNT**
Testosterone		
Prolactin		
Thyroid profile		
Semen Analysis		
Testicular Ultrasound		

MEDICINES	DOSAGE	AMOUNT
PROCEDURE(ICSI or IUF)	**DATE BOOKED**	**AMOUNT**
POST IVF MEDICATIONS AND FOLLOW UP	**DATE OF REVISIT**	**AMOUNT**

I have examined the patient and hereby recommend IVF as the beneficial treatment option for the patient's condition. I understand that it is an offence to knowingly make any false statement for purposes of obtaining any benefit under NHIF Act.

Facility stamp

Signature: _____ Date: _____

NOTE

- Please be advised that authorization is based upon the medical information provided. If services, providers or dates of services change from these indicated, NHIF must be notified prior to services being rendered.
- Payment for services rendered is subject to verification of outcomes of care and beneficiary eligibility as at the date of service provision. Contractual obligations with the provider take precedence.