



## Family Planning Authorization- Fax Cover Sheet

DATE:	
Member Name:	Member ID:

<b>Sterilization</b>	
Date Member Signed MA31:	
Hospital:	
Doctor/Practice:	NPI:
Date of Procedure:	Procedure Code:
EDC or Date of Scheduled Delivery:	Diagnosis Code:

<b>Pregnancy Termination</b>	
Hospital:	
Doctor/Practice	NPI:
Date of Procedure:	Procedure Code
Diagnosis:	Diagnosis Code:
Gestational Age:	

Contact Name:	Phone Number:
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How would you like to receive your authorization or denial notification?
If via secure Email, Email address:
If via Fax, Fax number:

**Please include all appropriate documentation (i.e. forms MA31, MA3, MA368/369)**

**Please Fax this form to Highmark Wholecare at (833) 559-2857**

**If you have questions, please call Highmark Wholecare family planning authorization team at (800) 532-9465**

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association (“Highmark Wholecare”).