

**ART Participation Form – Ohio Reproductive Medicine**

**We request that you call your insurance company and ask if you have benefits for in vitro fertilization (IVF) and injectable infertility medication.**

Please complete **all** of the information below and return together with the “Medication Inventory” to the address on the right. You should hear from our financial representative within one week of mailing the form. If you do not hear from us within that time frame then call us at 614-451-2280 x 155.

Ohio Reproductive Medicine  
ART Finance  
4830 Knightsbridge Blvd. Ste E  
Columbus, OH 43214

**Procedure**

<input type="checkbox"/> IVF	<input type="checkbox"/> IVF / ICSI with surgically retrieved sperm	<input type="checkbox"/> IVF – known egg donor
<input type="checkbox"/> ZIFT	<input type="checkbox"/> IVF / ICSI with naturally produced sperm	<input type="checkbox"/> IVF – anonymous egg donor
<input type="checkbox"/> GIFT	<input type="checkbox"/> FET	<input type="checkbox"/> IVF – gestational carrier

**Patient Information**

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone (\_\_\_\_) \_\_\_\_\_ O.K. to leave message? \_\_\_\_\_  
 Work phone (\_\_\_\_) \_\_\_\_\_ O.K. to leave message? \_\_\_\_\_  
 Cell phone (\_\_\_\_) \_\_\_\_\_ O.K. to leave message? \_\_\_\_\_  
 Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security number \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Employer \_\_\_\_\_

**Partner Information**

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_  
 Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security number \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Work Phone (\_\_\_\_) \_\_\_\_\_ O.K. to leave message? \_\_\_\_\_  
 Cell phone (\_\_\_\_) \_\_\_\_\_ O.K. to leave message? \_\_\_\_\_  
 Employer \_\_\_\_\_

**Insurance Information**

Primary insurance \_\_\_\_\_ Subscriber name \_\_\_\_\_  
 Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_  
 Provider / Authorization phone # \_\_\_\_\_  
 Secondary insurance \_\_\_\_\_ Subscriber name \_\_\_\_\_  
 Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_  
 Provider / Authorization phone # \_\_\_\_\_

**If we do not have a copy of your insurance card please provide us with one.**

**Please mark and complete all that apply:**

**IVF Medical Benefits**

- No, I do not have IVF benefits.
- Yes, I have IVF benefits and no authorization is required.
- Yes, I have IVF benefits and authorization is required.  
 The phone # for authorization is \_\_\_\_\_

**Injectable infertility Medicine Benefits**

- No, I do not have benefits for injectable infertility medicines.
- Yes, I do have benefits for injectable infertility medicines.  
 \_\_\_\_\_ I am not required to use any particular pharmacy.  
 \_\_\_\_\_ My medication must be ordered from this specific pharmacy: Name \_\_\_\_\_  
 Pharmacy Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Have you or your partner had your “tubes tied” or had a vasectomy? (circle one) Yes No  
 Expected period start date for the month you would like to begin your ART cycle: \_\_\_\_\_