



**GENDER-AFFIRMING PRE-CERTIFICATION  
REQUEST FORM**

**Fax to 510-642-9119**

**Questions? Please call 510-642-5700 and ask to speak with a member of the Trans Care Benefits Team.**

**Request will NOT be processed without required supporting documentation.**

Today's Date: \_\_\_\_\_

**Section A. Student information**

|               |                |                             |
|---------------|----------------|-----------------------------|
| Student Name: | Date of Birth: | SHIP (Wellfleet) ID Number: |
| <br><br>      | <br><br>       | <br><br>                    |

**Section B. Requesting Provider Information**

|          |            |  |      |
|----------|------------|--|------|
| Name:    | Specialty: | Phone:   | Fax: |
| Address: |            | In CA: Contracted with Blue Shield of CA PPO?<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br>Outside of CA: Contracted with Cigna PPO?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |      |

**Section C. Referred to Facility**

|  |                              |  |      |
|--|------------------------------|--|------|
| Name:  | Date of admission/procedure: | Phone:   | Fax: |
| <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient |                              |  |      |
| Address:   |                              | In CA: Contracted with Blue Shield of CA PPO?<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br>Outside of CA: Contracted with Cigna PPO?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |      |

**Section D. Services requested**

|   |  |
|---|--|
| Primary diagnosis related to the service(s) requested (please only indicate primary diagnosis): | Corresponding Diagnosis Code (ICD-10): |
| <br><br>  |  |
| Service(s) being requested (Please use CPT codes and descriptions):                             | Number of visit(s) or length of stay:  |
| <br><br>  |  |

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