State of Connecticut

INFERTILITY TREATMENT AND PROCEDURES DISCLOSURE FORM

Effective October 1, 2005, Public Act 05-196 requires any individual seeking health insurance coverage for infertility treatment and procedures to disclose to the individual's existing health insurance carrier any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. For more information, please see Public Act 05-196 which can be accessed at the Connecticut General Assembly website at http://www.cga.ct.gov/2005/act/Pa/2005PA-00196-R00SB-00508-PA.htm

THIS FULLY COMPLETED FORM IS TO BE SENT TO CURRENT HEALTH INSURANCE CARRIER

Name of Individual Seeking Treatment_____

Date of Birth:_____ Social Security Number_____

Current Insurance Carrier _____Policy/ID #_____

Insured under this policy since:_____

[ ] Individual Plan [ ] Group Plan Name of Group:_____ Policy/ID #_____

Covered as: [ ] Insured [ ] Dependent

Insured Name_____

Prior Insurance Carrier:_____Dates of coverage:_____

[ ] Individual Plan [ ] Group Plan Name of Group:_____ Policy/ID #_____

Was this plan insured or self-funded? [ ] Insured [ ] Self-funded

Rx Carrier:_____ Policy/ID#:_____

Covered as: [ ] Insured [ ] Dependent (Name if different:_____)

Prior Insurance Carrier:_____Dates of coverage:_____

[ ] Individual Plan [ ] Group Plan Name of Group:_____ Policy/ID #_____

Was this plan insured or self-funded? [ ] Insured [ ] Self-funded

Rx Carrier:_____ Policy/ID#:_____

Covered as: [ ] Insured [ ] Dependent (Name if different:_____)

Attach separate sheet if more space is needed to answer any question fully.

State of Connecticut

INFERTILITY TREATMENT AND PROCEDURES DISCLOSURE FORM

Previous infertility treatment or procedures covered by insurance (do not include treatment or procedures for which no insurance claim was made, submitted or paid) :

Treatment or Procedure (including drug therapy)	Number of Cycles	Dates Received	Name, Address, Phone of Provider Providing Treatment	Health Insurance Coverage Provided By

Other infertility treatment or procedures received: (please describe and provide dates and name of health insurer)

State of Connecticut

INFERTILITY TREATMENT AND PROCEDURES DISCLOSURE FORM

I have reviewed the information submitted in accordance with Public Act 05-196, and attest that the information is true and accurate. I hereby certify that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief. I acknowledge that I understand that a person who knowingly makes or causes to be made, or used, a false record or statement will be considered to commit insurance fraud for the purposes of receiving benefits to which the person is not entitled.

_____ _____

(Signature of Insured Individual Seeking Treatment) (Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____day of _____,

20_____ By _____, and:

☐ who is personally known to me, or ☐ who produced the following identification:

[SEAL]

_____
Notary Public

_____
Printed Notary Name

_____
My Commission Expires

Authorization to Release Medical Information

I, _____ hereby authorize the release of medical records necessary to verify previous infertility treatment and procedures. I understand that these records may be obtained from any and all previous health insurers and/or any relevant medical provider(s) and will be utilized solely for the purpose of determining previous infertility treatment and procedures applied towards the maximums identified in Connecticut Public Act 05-196.

_____ _____

Signature of Patient **Date**