ILLINOIS DEPARTMENT OF Healthcare and Family Services

Fee-for-Service Submittal Detail
Forms should be submitted via email:
hfs.ga-service@illinois.gov

Prior Authorization for Gender-Affirming Services

1. CLIENT INFORMATION

Client First and Last Name:	Date of Birth:	RIN:	Sex Assigned at Birth	Identifying Gender:

Address:	City:	State:	Zip Code:	County:

Phone Number:	

Guardianship Status: ☐ None ☐ Personal Representative* ☐ Minor*

If Personal Representative or Minor selected, complete Parent or Guardian Info below.

Parent or Guardian Info.

First and Last Name: _____ **Relationship to Client:** ☐ Parent ☐ Guardian **Phone Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____ **County:** _____

2. DIAGNOSIS: List all known relevant diagnosis information for the client.

DSM-5 Diagnosis:		ICD- 10 Diagnosis:		Primary
Code	DSM-5 Name	Code	ICD-10 Name	
				☐
				☐
				☐
				☐
				☐

3. TREATMENT SERVICES REQUIRING PRIOR AUTHORIZATION

Requested Treatment	ICD- 10 Procedure:		Genital Surgery
Service / Procedure	Code	ICD – 10 Name	
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

4. RECIPIENT'S TREATMENT TEAM: List additional providers on a separate document and submit as an attachment.

Primary Care Physician (PCP)	**Organization Name**	**Contact Name**	**Phone:** **Email:**
Physician Leading Treatment ☐ **Same as PCP**	**Organization Name**	**Contact Name**	**Phone:** **Email:**
LPHA Name	**Organization Name**	**Contact Name**	**Phone:** **Email:**

5. FORM SIGNATURE

Staff Responsible for Completing Form

Staff Completing (print name)	Credentials	Phone Number:

Signature	Date (mm/dd/yyyy)

Provider Name:	NPI:	HFS Provider ID:

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MANDATORY: Primary Care Physician or Physician Leading Client's Gender-related Healthcare Component

My signature below certifies that the individual named in Section 1 of this document:

1. ☐ Is at least 21 years of age; or

   ☐ Is under 21 years of age but clearly demonstrates sufficient medical necessity for the treatment being requested in Section 3 of this document as detailed in my written summary attached to this form;
2. Has the capacity to make a fully informed decisions and to consent to the treatment being requested in Section 3 of this document;
3. Has the diagnosis of Gender Dysphoria;
4. ☐ Has no other significant medical or mental health conditions that would be a contraindication to the gender-affirming surgery, service or procedure; or

   ☐ Has one or more other significant medical or mental health conditions that would be a contraindication to the gender-affirming surgery, service or procedure but such conditions are reasonably well-controlled;
5. ☐ Has received hormone therapy appropriate to the individual's gender goals since: _____/ _____/ _____, a period minimally covering 12 months if the individual is seeking genital surgery;

   ☐ Has not received hormone therapy as it is contraindicated;

   ☐ Has not received hormone therapy as the individual is unable to take hormones; or

   ☐ Not applicable, as the requested treatment service does not include genital surgery; and
6. ☐ Has lived continuously, for a period minimally covering 12 months, in the gender role congruent with the individual's gender identity since: _____/ _____/ _____; or

   ☐ Not applicable, as the requested treatment service is not Genital Surgery.

Furthermore, I certify that:

1. I have sought to identify and communicate with the individual's other medical provider(s) regarding the proposed surgery, service, or procedure;
2. The service(s) being requested in Section 3 of this document is/are, in my medical opinion, medically necessary; and
3. I have detailed the following recommendations for post-operative care with the client:

_____

_____

_____

_____

ATTACHMENT

This document must be accompanied by the:

1. Physician letter; and
2. Supporting medical documentation.

Primary Care Physician or Physician Leading Client's Gender-related Healthcare

Physician (print name)	Credentials	NPI #

Signature	Date (mm/dd/yyyy)

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LPHA Component – Required ONLY for Genital Surgery

My signature below certifies that the individual named in Section 1 of this document:

1. ☐ Is at least 21 years of age; or

   ☐ Is under 21 years of age but clearly demonstrates sufficient medical necessity for the treatment being requested in Section 3 of this document as detailed in my written summary attached to this form;
2. Has the capacity to make fully informed decisions and to consent to the treatment being requested in Section 3 of this document;
3. Has the diagnosis of Gender Dysphoria;
4. ☐ Has no other significant medical or mental health conditions that would be a contraindication to the gender-affirming surgery, service or procedure; or

   ☐ Has one or more other significant medical or mental health conditions that would be a contraindication to the gender-affirming surgery, service or procedure but such conditions are reasonably well-controlled;
5. Has participated in the following services provided by, or administered by, myself:

   ☐ A comprehensive mental health assessment,

   ☐ Psychotherapy, if clinically appropriate, and

   ☐ Education and counseling of treatment options and implications of receiving the services detailed in Section 3 of this document.

ATTACHMENT

This document must be accompanied by the:

1. LPHA letter; and
2. A copy of the client's mental health assessment.

LPHA Component – Required for Genital Surgery

LPHA (print name)	Credentials	NPI #

Signature	Date (mm/dd/yyyy)

Instructions for the Submission of the Prior Authorization Request for Gender-Affirming Services

INSTRUCTIONS

Required for ALL gender-affirmation treatment and services

Section 1 – Client Information

1. Client First and Last Name. Enter the full name, first and last, of the individual seeking the service.
2. Date of Birth. Enter the date of birth of the individual seeking the service.
3. RIN. Enter the State of Illinois recipient identification number (RIN) of the individual seeking the service.
4. Sex Assigned at Birth. Provide the sex designation of the individual seeking the service.
5. Identifying Gender. Provide the gender of the individual seeking the service that the individual actively identifies with.
6. Address. The street address of the residence of the individual seeking the service.
7. City. The city of the residence of the individual seeking the service.
8. State. The state of the residence of the individual seeking the service.
9. Zip Code. The zip code of the residence of the individual seeking the service.
10. County. The county of the residence of the individual seeking the service.
11. Phone Number. The phone number of the individual seeking the service.
12. Guardianship Status. The guardianship status of the individual seeking service.
13. Parent or Guardian Info. Only used for individuals seeking service that have selected "Personal Representative" or "Minor," the Parent or Guardian Information section should detail the: name (first and last), relationship to client, phone number, and residential address (address, city, state, zip code, and county) of the individual capable of making medical decisions and consenting to services on behalf of individual seeking service.

Section 2 – Diagnosis

1. DSM-5 Diagnosis. List all known, relevant DSM diagnoses of the individual seeking service.
2. ICD-10 Diagnosis. List all known, relevant ICD-10 diagnoses of the individual seeking service.
3. Primary Indicator. Please indicate, from the list of diagnoses provided, the primary diagnosis that necessitating the services being requested.

Section 3 – Treatment Services Requiring Prior Authorization

1. Requested Treatment. Under the heading of "Service / Procedure," please list the name of the procedure(s) that the individual seeking service has consented to have performed and requires Prior Authorization.
2. ICD-10 Procedure. Please Provide the ICD code and name for the procedure(s) to be performed under the heading "Code" and "ICD-10 Name," respectively.
3. Genital Surgery. In the event that the service or procedure being sought includes genital surgery, please indicate "Yes" under the heading "Genital Surgery". In the event that the service or procedure being sought does not include genital surgery, please indicate "No".

Section 4 – Recipient's Treatment Team

1. Primary Care Physician. Please list the name (first and last) of the individual's Primary Care Physician (PCP).
2. Organization Name. If the Practitioner works for a medical group, practice group, community mental health center, hospital, or other entity, please provide the name of the entity.
3. Contact Name. Please provide the name (first and last) of the most appropriate person to contact (e.g. receptionist, assistant, nurse) when seeking to talk with named Practitioner.
4. Phone. Please provide the most appropriate phone number to contact the listed Practitioner.
5. Email. Please provide the most appropriate email to contact the listed Practitioner.
6. Physician Leading Treatment. Please list the name (first and last) of the physician leading the gender-affirming services. In the event that this Practitioner is the same as the PCP listed in the line above it, the "Same as PCP" box may be selected and the Name, Organizational Name, Phone and Email for the Physician Leading Treatment may be skipped.
7. LPHA Name. Please provide the name (first and last) of the Licensed Practitioner of the Healing Arts (LPHA) that is participating on the treatment team. An LPHA may not always be required. However, when the request for prior authorization includes services that include genital surgery, an LPHA is required to be listed in this box/section.

See Note on Qualifying LPHA's found in the "Section 7 – Attestation 2 – LPHA" instructions.

***Note**:* All additional treatment team practitioners should be provided on an additional sheet of paper as an attachment to submitted document.

Section 5 – Form Signature

1. Staff Completing. Please list the name (first and last) of the individual completing the form.
2. Credentials. Please list the credentials associated with the individual completing the form, if the individual is a licensed practitioner in the state in which they are employed. If the individual completing the form is not a licensed practitioner, please provide the role that the individual completing the form holds within their organization (e.g. UM Nurse, Records Associate, etc.).
3. Phone Number. Please provide the most appropriate phone number to contact the individual completing the form.
4. Signature. The person completing the form must sign the document in this box.
5. Date. The person completing the form must provide the date that they signed the form.
6. Provider Name. The name of the entity or practitioner that the person completing the form is representing in the submission of the Prior Authorization request.
7. NPI. The National Provider Identification number for the entity listed in the "Provider Name" box.
8. HFS Provider ID. The provider identification number for the entity listed in the "Provider Name" box, as assigned by HFS at the point of enrollment in the Illinois Medical Assistance program. This number is usually a combination of the provider's 9-digit FEIN and a three digit location code assigned by HFS.

Instructions for the Submission of the Prior Authorization Request for Gender-Affirming Services

Section 6 – Attestation 1 – Physician

***Note**:* All gender-affirming services require the completion of this section.

1. Check Boxes. The physician must construct an attestation using the various, pre-defined options under each item number. Each selection must be clearly and visibly marked on the form. Any section item that is not clearly marked or left incomplete may result in a slowed review, required contact with the Prior Authorization Agent, or a denial of the request.
2. Supply Dates. Some of the check box options provided requires the physician to insert a corresponding date. In these instance, the physician should provide the date that satisfies the statement being made in the following format:
   When Month = m, Day = d, and Year = y; dates should be supplied as: **mm/ dd/ yyyy**.
3. Post-operative Care Detail. In the event that the individual seeking services requires post-operative care, such post-operative care should be detailed on the lines provided. In the event that the post-operative care detail requires more space than available on the form, please provide the additional detail on a separate sheet of paper as an attachment to this document.
4. Attachments. Minimally, the attestation signed by the physician should be accompanied by the physician's written letter and medical documentation supporting the overall medical necessity of the services being requested. Documents may include a pre-op treatment report, treatment plan, clinical notes, or other elements needed to support the request for treatment.
5. Signature. The physician must sign the attestation and provide their: name (first and last), credentials, National Provider Identification number (NPI), and provide the date of signature in the **mm/ dd/ yyyy** format, as detailed above in these instructions.

Required for gender-affirmation treatment and services resulting in genital surgery

***Note**:* With any completed Gender-affirming Service Prior Authorization Request that details one or more procedures that includes genital surgery, this section is REQUIRED. For Gender-affirming Service Prior Authorization Requests that DO NOT include genital surgery, this section is not required.

In the event that services requested on the submitted prior authorization request form includes genital surgery and this section is not completed – the Prior Authorization Request will be denied on the basis of "**Insufficient documentation supplied**".

Section 7 – Attestation 2 – LPHA

***Note on Qualifying LPHA's**:* For the purposes of Gender-affirmation Service delivery and requests for Prior Authorization of Gender-affirmation Services, qualified LPHA's are detailed in 89 Ill. Adm. Code 140.453 (a-d, f) as:

1. A physician who holds a valid license in the state of practice and is legally authorized under state law or rule to practice medicine in all its branches, so long as that practice is not in conflict with the Medical Practice Act of l987;
2. An advanced practice nurse with psychiatric specialty that holds a valid license in the state of practice and is legally authorized under state law or rule to practice as an advanced practice nurse, so long as that practice is not in conflict with the Illinois Nurse Practice Act or the Medical Practice Act of 1987;
3. A clinical psychologist who holds a valid license in the state of practice and is legally authorized under state law or rule to practice as a clinical psychologist, so long as that practice is not in conflict with the Clinical Psychologist Licensing Act;
4. A licensed clinical professional counselor possessing a master's degree who holds a valid license in the state of practice and is legally authorized under state law or rule to practice as a licensed clinical professional counselor, so long as that practice is not in conflict with the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]; or
5. A clinical social worker possessing a master's or doctoral degree who holds a valid license in the state of practice and is legally authorized under state law or rule to practice as a social worker, so long as that practice is not in conflict with the Clinical Social Work and Social Work Practice Act.

***Note*:** The Illinois Administrative Code on Gender-affirming services requires the submission of two (2) letters of medical necessity, in the event that the individual seeking services elects to receive a service that includes genital surgery. As multiple, independent letters are required to support the request for genital surgery, the Physician providing the Physician Attestation cannot also qualify as the treatment team LPHA for the purposes of completing the LPHA Attestation.

1. Check Boxes. The LPHA must construct an attestation using the various, pre-defined options under each item number. Each selection must be clearly and visibly marked on the form. Any section item that is not clearly marked or left incomplete may result in a slowed review, required contact with the Prior Authorization Agent, or a denial of the request.
2. Attachments. Minimally, the attestation signed by the LPHA should be accompanied by the LPHA's written letter and a copy of the comprehensive mental health assessment for the individual seeking services, as supporting medical documentation to this request.
3. Signature. The LPHA must sign the attestation and provide their: name (first and last), credentials, National Provider Identification number (NPI), and provide the date of signature in the mm/ dd/ yyyy format, as detailed above in these instructions.

Note: If the services being provided include genital surgery that may result in the sterilization of the individual seeking services, the Gender-affirming Services Prior Authorization Request must be submitted with a completed HFS Form: **HFS 2189**, as an attachment to the request. The HFS 2189 can be found at the following location: **https://www.illinois.gov/hfs/SiteCollectionDocuments/hfs2189.pdf.**

Submittal of Request

Upon the completion of the Gender-affirmation Services Prior Authorization Form, the gathering and/ or development of all necessary documentation and attachments, and signature of attestations by appropriate licensed practitioners – the document should be submitted to HFS and its review agent via email at:

hfs.ga-service@illinois.gov