Authorization Checklist

Patient Name:

Patient Date of Birth:

Primary Physician:

Practice Location:

Is the member aware you're reaching out for this authorization and planning to move forward with this start date: (Y/N)

Is the member medically cleared- (Y/N)

Where Applicable:

Standalone Service
- Appointment Date:
- Cycle or Treatment Type:

Initial Consult
- Date of completed Initial Consult:

Egg Freezing or IVF*
- Injectible medication start date or baseline ultrasound date:

Intrauterine Insemination
- Baseline ultrasound date:
- Medicated Cycle (Y/N):

Frozen Embryo Transfer*
- Supression scan date:

Previous cycle
- Cycle type, start and end dates:

* Transfer cycle authorizations are approved for a single embryo transfer only unless approval from Progyny's Medical Advisory Board is obtained.