VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERIVCES (DMAS)
GENDER DYSPHORIA SERVICE AUTHORIZATION FORM
DMAS-P264

Submit the completed Service Authorization form, and specified documentation, via fax to the DMAS Medical Support Unit (see below) at least **30 days** prior to scheduled date of procedures/services:

DMAS MEDICAL SUPPORT UNIT
Fax **804-452-5450**
Phone **804-786-8056**

Final approval is contingent upon passing member and provider eligibility/enrollment edits. The Service Authorization (SRV AUTH) number provided by the DMAS Fiscal Agent will be available to providers through the Automated Response System [Medicall system] within 24 hours (or the next business day) if reviewed and approved. Please refer to the Virginia Medicaid Provider Manuals, Chapter I, General Information, for instructions on how to access these systems.

SECTION I: PATIENT INFORMATION

FULL NAME	DOB	MEDICAID ID NUMBER
HOME ADDRESS		

SECTION II: PROVIDER INFORMATION

FULL NAME	NPI
PHONE (direct line for ordering provider)	FAX
CONTACT NAME (if different from provider)	
CONTACT PHONE (if different from provider)	CONTACT FAX (if different from provider)

SECTION III: FACILITY INFORMATION

FULL NAME	NPI
STREET ADDRESS	FAX
ZIP CODE	
CONTACT NAME and DEPARTMENT	
CONTACT DIRECT PHONE NUMBER	CONTACT FAX

SECTION IV: DIAGNOSIS*

* Claims must be submitted with an F64 ICD-10 diagnosis code

See the Gender Dysphoria Supplement of the DMAS Provider Manual for policy details, including a list of potentially appropriate billing codes, and the appropriate "Type of Service" each billing code represents.

SECTION V: BILLING DETAILS

1. **Please select which type(s) of procedure(s) authorization is being sought for, and specify the billing code(s) & date(s) of service of the relevant procedure types:**

Billing Code	Type of Service	# Units	Date of Service
i.e. CPT/HCPTS code *See the Gender Dysphoria Supplement of the DMAS Physician/Practitioner Provider Manual for potentially appropriate billing codes & "Type of Service" each constitutes*	Please specify the Type of Service (1-3) each billing code reflects. See the Gender Dysphoria Supplement for billing code-specific designations: **1**: FACIAL FEMINIZATION OR MASCULINIZATION **2**: BREAST/CHEST GENDER AFFIRMING SURGERIES **3**: GENITAL GENDER AFFIRMING SURGERIES *Types of Service* #1 & #2 require all specified LMHP documents from **one (1)** LMHP provider. *Types of Service* #3 require LMHP documents from **two (2)** LMHP providers.		

SECTION VI: CLINICAL AUTHORIZATION

2. **Please attach documentation from the requisite number of licensed mental health providers (LMHP) (see SECTION IV), either via letter of support or a copy of the providers' latest treatment note, dated within the last 12 months and including all of the following:**
    a. Member's general identifying characteristics; and
    b. Description of how the provider meets the definition of an LMHP; and
    c. Documentation of the diagnosis of gender dysphoria meeting DSM-V Criteria, including the following:
        i. Date of onset; and
        ii. Duration of the LMHP's relationship with the member; and
        iii. Results of the member's psychosocial assessment; and
        iv. Any relevant diagnostic history; and
        v. The type of evaluation and therapy or counseling undertaken to date; and

d. A description of the clinical rationale supporting the recommendation for the covered service; and
e. Progress notes documenting that coexisting behavioral health and medical comorbidities or social problems that may interfere with diagnostic procedures or treatment are being appropriately treated and are not causing the member's gender dysphoria; and

3. **For authorizations for *BREAST/CHEST GENDER AFFIRMING SURGERIES* or *GENITAL GENDER AFFIRMING SURGERIES* (see SECTION IV), please attach documentation from one of the members' treating providers, either via letter of support or a copy of a providers' latest treatment note, dated within the last 12 months and including all of the following:**
    a. Confirmation that members have satisfied any requirements around hormone therapy, as outlined in the Gender Dysphoria Supplement of the DMAS *Physician/Practitioner Provider Manual*, including all of the following:
        i. The date the member started hormone therapy; and
        ii. The member's adherence to the prescribed regimen; and
        iii. The member's clinical response over the course of hormone therapy; or
        iv. A detailed description of the member's contraindication to, intolerance of, or refusal of hormonal therapy
4. **For authorizations for *GENITAL GENDER AFFIRMING SURGERIES* (see SECTION IV), please attach documentation from one of the members' treating providers, either via letter of support or a copy of a providers' latest treatment note, dated within the last 12 months and including all of the following:**
    a. Confirmation that members have satisfied any requirements to live full-time as the gender congruent with their identity, as required above, including all of the following:
        i. The date the member started living as the gender congruent with their identity; and
        ii. The member's experience living as the gender congruent with their identity; or
        iii. The one medical provider's and one licensed mental health professional's rationale for why this requirement is not safe for the patient
5. **Please attach documentation from the treating proceduralist, either via letter of support or a copy of the provider's latest treatment note, dated in the last 12 months and including all of the following:**
    a. Description of how the proceduralist meets WPATH-7 competency guidance, including all of the following:
        i. For *Breast/Chest Gender Affirming Surgeries* and *Genital Gender Affirming Surgeries*, training and licensure in an appropriate field (general surgery, gynecology, plastic surgery, urology); and
        ii. For *Genital Gender Affirming Surgeries*, specialized competence in genital reconstruction; and
    b. Description of any recommended electrolysis or laser hair removal, including all of the following:
        i. Explanation of the medical necessity of the procedure, be it preoperative or involving the face, head and/or neck; and
        ii. Licensure of the qualified professional performing any covered electrolysis or laser hair removal; and
    c. An attestation that the proceduralist has reviewed the member's care with the asserting licensed mental health provider(s) and the health care professional providing hormone therapy, if applicable; and
6. **Please attach a signed informed consent form obtained by the proceduralist, including confirmation of the members' understanding and receipt of oral and written information addressing all of the following:**
    a. The different procedural techniques available (including referrals to colleague where appropriate) including advantages and disadvantages of each; and
    b. The risks and complications of the proposed procedure, including the provider's own complication rates; and
    c. For any *Genital Gender Affirming Surgeries*:
        i. That the service may/will make the individual permanently incapable of reproducing
        ii. Options for preservation of fertility, including a review of the services not covered by Virginia Medicaid.

7. **For patients undergoing hysterectomy, please attach a copy of the completed DMAS-3005 *Acknowledgement of Receipt of Hysterectomy Information* Form.**

_____ _____

SIGNATURE (Provider) DATE

Department Use Only

___ Approved ___ Denied ____ Return for additional information noted below:

_____
_____
_____

Reviewer Name:

Reviewer Date: