

# ILLINOIS FERTILITY REIMBURSEMENT MEDICAL CLAIM FORM

For Medical claims only - Please complete one form per member

## Purpose of Form

Use this form to request reimbursement for a surrogate or donor's fertility-related services provided to **non-members**, as part of a member's fertility benefit coverage. Ambetter of Illinois covers certain fertility services including, but not limited to the following: in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, surgical sperm extraction procedure, low tubal ovum transfer, screening & diagnosis of a fertilized egg, genetic testing, etc. Specific benefit codes are included at the end of this form. Please provide member and benefit information below. For any questions, please reach our member services team at 1.855.745.5507.

## Instructions

1. You will need your health care provider to assist and supply information to complete this form, including providing procedure code(s) and diagnosis code(s) from the provider's superbill. Please also refer to the Help Sheet for additional information.
2. To request reimbursement, please submit the following to the address listed at the bottom of this form within one year from the date of service:
  - a. This completed and signed reimbursement form;
  - b. Proof of services rendered;
  - c. Itemized proof of payment for the services being requested for reimbursement; and
  - d. An itemized list of services or retail items for reimbursement review.
3. Most complete reimbursement requests are processed within 45 days. Incomplete requests may result in a delay or a denial of the request.
4. Reimbursement will be sent to the Member (see Help Sheet for definition) at the address Ambetter of Illinois has on record (To view your address of record, please log on to [AmbetterofIllinois.com](http://AmbetterofIllinois.com) or call Member Services at 1-855-745-5507 (TTY 1-844-517-3431)).
5. Retain a copy of all receipts and documentation for your records.

## Ambetter Subscriber/Member Information

Last Name:	First Name:	Middle Initial:	Ambetter Member ID:
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## Surrogate or Donor Information

Last Name:	First Name:	Middle Initial:
Date of Birth (MM/DD/YYYY):		Mailing Address:
Telephone Number:	Surrogate/Donor Email Address:	Does Surrogate/Donor have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Did that Insurance make a payment: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include plan's EOB)
Insurance Company Name:	Insurance Company Phone Number:	Insurance Policy Number:

## Claim Information (This section must be completed and may require the health care provider to assist in completion.)

Healthcare Provider's Name:	Healthcare Provider's NPI Number:	Healthcare Provider's Federal Tax ID #:	Healthcare Provider's Telephone Number:
Organization/ Group Name:	Organization/ Group NPI Number:	Organization/ Group Telephone Number:	Setting where treatment was received:
Healthcare Provider's Address:			Were services received outside of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No

Detailed explanation of visit/services, including date(s) of the visit/services, and explanation if a non-contracted provider was utilized:

Diagnosis Codes	Diagnosis Description (e.g., Pregnant state gestational carrier, or counseling for gestational carrier, advice on procreation or Oocyte donor)	Date(s) of Service	Procedure Codes (for each service provided) *	Procedure Descriptions (e.g., Fertility Treatment.) *	Amount Paid
.		/ /			\$
.		/ /			\$
.		/ /			\$
.		/ /			\$

**No more than 30 days/ one month of reimbursement requests per form.**

\* Procedure and diagnosis codes may not be available for retail or foreign provider claims.

† One year requirement will be waived if you or your covered dependent member had no legal capacity to submit such proof during that year.

**Surrogate or Donor signature is required**

**Total Amount  
Total Amount Paid**

\$

Ambetter of Illinois complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. Ambetter of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

For the Surrogate/Donor:

I attest, as the surrogate &/or donor, that I received the services as submitted in conjunction with an Ambetter of Illinois member's health benefits.

\_\_\_\_\_  
Surrogate/Donor Printed Name

\_\_\_\_\_  
Surrogate/Donor Signature

\_\_\_\_\_  
Date

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I, as the Ambetter of Illinois member, attest that services provided were in conjunction with my infertility benefit. I understand that these benefits will be applied to my insurance contract. I acknowledge that if any information on this form is misleading or fraudulent, my coverage may be cancelled, and I may be subject to criminal and/or civil penalties for false health care claims. I understand that reimbursement payment will be made to the Plan subscriber and will contain information about the service (e.g., provider name, date, description of service).

I also understand that Ambetter of Illinois may request any additional information it deems necessary to verify that services were received, and payment was made.

\_\_\_\_\_  
Member's Printed Name

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

**Checklist**

1. I have completed and signed this form in its entirety.
2. I have enclosed documents of Proof of Services received (see the help sheet for an example of proof of services).
3. I have enclosed documents of Payment of Services – not related to copay or plan deductible (see the help sheet for an example of proof of payment).
4. I understand that most completed reimbursement requests are processed within 45 days. Incomplete requests may take longer.

**Please submit this form and all documentation to:**

Ambetter of Illinois • Claims Department-Member Reimbursement • P.O. Box 5010 • Farmington, MO 63640-5010

**ILLINOIS FERTILITY REIMBURSEMENT  
HELP SHEET / FAQs**

<b>Question</b>	<b>Answer</b>
What is this form used for?	This form is used to request reimbursement payment for eligible out-of-pocket expenses related to surrogate or donor services that otherwise would be covered under the Ambetter member's policy.
What is the financial responsibility of the member and the member benefit related to the Fertility reimbursement?	Copayments, deductibles, coinsurance, and non-covered services will be the Ambetter subscriber's responsibility. If the surrogate/donor receives care from an out-of-network provider and the provider bills more than the Usual, Reasonable, and Customary charge, the subscriber will be responsible (i.e. balance billed) for the sum of the co-insurance amount and any amount that is over the Usual, Reasonable and Customary charge. <b>THIS IS NOT A GUARANTEE OF PAYMENT.</b> Actual payment for the service covered will be paid at the appropriate level according to your plan benefits and you may be billed for the difference between Ambetter Health's allowed amount and the providers billed charges.
What happens next?	After processing the Subscriber's reimbursement request, the Subscriber will receive an Explanation of Benefits (EOB). The EOB explains the charges applied to the subscriber's deductible (the fixed dollar amounts the subscriber pays for covered services before the insurer starts to make payments) and any charges the subscriber may owe the provider. Subscribers may keep the EOB on file in case it's needed in the future. Members and non-members may also refer to the Evidence of Coverage (EOC) on <a href="http://AmbetterofIllinois.com">AmbetterofIllinois.com</a> .
Who should I contact if I need help with completing this form?	Contact Member Services at 1-855-745-5507 (TTY 1-844-517-3431)
<b>Field Name</b>	<b>Description</b>
Subscriber Information	The Subscriber is the person: Who enrolls in an Ambetter Health Plan and signs the membership application form on behalf of him/herself and any dependents, and In whose name the premium is paid.
Subscriber's Ambetter Member ID#	ID# with suffix, found on the front of the Ambetter of Illinois Member ID card.
Surrogate &/or Donor's Name	Last and First names and Middle Initial of the surrogate &/or donor who received services.
Surrogate &/or Donor's Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits).
Provider's Name, Address, Telephone Number, Provider Federal Tax ID #:	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, durable medical equipment suppliers.
In what setting did the surrogate &/or donor receive treatment?	Such as office, emergency room, outpatient hospital (for X-rays, tests), inpatient hospital, clinic, medical supply store.
If services were rendered outside of the U.S.	Out of the country services are not a covered benefit and will not be reimbursed.
Diagnosis: What was the surrogate &/or donor seen for?	Provide a diagnosis code and detailed description of illness or injury. (e.g., Fertility Counseling, or Treatment (in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.)
Date(s) of Service	The date(s) the services were provided to the surrogate &/or donor.
Procedures, Services, or Supplies Provided	Provide a procedure code and detailed description. (e.g., x-ray, office visit, lab work, leg cast, etc.)
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was (actually) rendered, listing date(s) of service, service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment <b>if</b> made by the surrogate or <b>donor</b> was received by the provider of service. Examples include: The front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address preprinted on the receipt, with items listed and amount paid.

**Please submit this form and all documentation to:**

Ambetter of Illinois • Claims Department-Member Reimbursement • P.O. Box 5010 • Farmington, MO 63640-5010

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**AMB22-AL-C-00098**

**Benefits listed are subject to all provisions and limitations as outlined in the Subscriber's Evidence of Coverage (EOC). Please refer to the Subscriber's EOC for details regarding the benefits listed below. The Subscriber is responsible for deductible, copayment or coinsurance applied to eligible service expenses. For services that require prior authorization, network providers must obtain authorization from us prior to providing a service or supply to a Surrogate or Donor. You should confirm with your provider that they have received prior authorization for a covered service prior to treatment. This list is not a conclusive list of covered codes and services but are more commonly billed.**

IL Surrogate Donor Benefit Coverage				
Service	Description	Procedure Code	In Network Coverage	Out Of Network Coverage
Pre-Surrogacy Office, Telehealth Consultations	Pre-surrogacy Consultants	99202-99215 (Office E & M) 99441-99443 (Telephone Services) 98000-98003 (New Audio/Video) 98004-98007 (Established Audio/Video) 98008-98011 (New Audio-Only)	Covered	Not Covered without Prior Authorization
Pre-Lab &	Prelab to determine compatibility to sustain pregnancy may include: (psychological screening, Blood & Urine Test: Reproductive health assessment (Pap smear, cervical swabs (for infections like Chlamydia and Gonorrhea), a pelvic ultrasound to examine the uterus and ovaries, and potentially a saline infusion sonogram or hysteroscopy to evaluate the uterine lining) Blood type and RH factor, Hormone Levels, Drug Screening)	96156 or 96167, 96130, 96131, 96132, 96133, 90846, 90847 for mental health professional (MHP) counseling. 96041, 96040 genetic counseling 85025, 80053, G0402, G0438, G0439 blood pressure; body mass index (BMI); physical exam; preventive screening; and counseling. S0610, S0612, S0613 Annual Gynecological Exams Kidney Function Testing (Creatinine): 82565,82575, 82570 Pregnancy Testing: 81025, 84702, 84703 Drugs: J0739, J0750, J0751 Blood Draw: 36415,36416 86689, 86701, 86702, 86703, 87389, 87390, 87391, 87806, G0432, G0433, G0435, G0475, S3645, 80081 Chlamydia Infection Screening: 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87492, 87801, 87801, 87810, 0455U, 0402U, 0557U Blood Draw: 36415,36416 Gonorrhea screening: 87590, 87591, 87592, 87801, 87850, 0557U Blood Draw: 36415,36416 Pap: 99381-99397 for commercial payers for the collection, and 88141-88177 for the interpretation of the specimen Drug Testing: 80305, 80306, 870307 70040: Hysterosalpingography (HSG) 70041: Hysterosalpingography with dye injection 70042: Hysterosalpingography, bilateral tubal occlusion 70043: Hysterosalpingography, unilateral tubal occlusion 70044: Hysterosalpingography, postpartum 70045: Hysterosalpingography, with pelvic or abdominal ultrasound guidance 70050: Transvaginal ultrasound, with interpretation, for infertility evaluation 70051: Transvaginal ultrasound, with interpretation, for infertility evaluation, with contrast 70052: Transrectal ultrasound, with interpretation, for infertility evaluation 70053: Transrectal ultrasound, with interpretation, for infertility evaluation, with contrast 70054: Hysteroscopy, diagnostic 70055: Hysteroscopy, diagnostic, with biopsy 70056: Hysteroscopy, diagnostic, with lysis of adhesion 70057: Hysteroscopy, diagnostic, with lysis of adhesion, with biopsy 70058: Hysteroscopy, surgical, lysis of adhesion	Covered	Not Covered without Prior Authorization

		<p>70059: Hysteroscopy, surgical, lysis of adhesion, with biopsy</p> <p>70060: Laparoscopy, diagnostic, for infertility evaluation</p> <p>70061: Laparoscopy, surgical, for infertility evaluation</p> <p>70062: Laparoscopy, surgical, for infertility evaluation, with biopsy</p>		
Fertility Treatment	In-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection.)	<p>58970 Follicle Puncture for Oocyte retrieval, any Method (IVF)</p> <p>58974 Intrauterine embryo transfer</p> <p>89250 Culture of oocyte(s)/embryo(s), less than 4 days</p> <p>58976 This code is for gamete, zygote, or embryo intrafallopian transfer, which involves transferring the embryo into the fallopian tube, not the uterus.</p> <p>89251 Culture of oocyte(s)/Embryo(s), less than 4 days; with co-culture of oocyte(s)/embryo(s)</p> <p>89253 Assisted embryo hatching, microtechniques (any method)</p> <p>89254 Oocyte identification from follicular fluid</p> <p>89255 Preparation of embryo for transfer (any method)</p> <p>89257 Sperm identification from aspiration (other than seminal fluid)</p> <p>89260 Sperm isolation; simple prep (e.g. spermwash and swim-up) for insemination or diagnosis with semen analysis</p> <p>89261 Sperm isolation; complex prep (e.g Percoll gradient, albumin gradient for insemination or diagnosis with semen analysis)</p> <p>89268 Insemination of oocytes</p> <p>89272 Extended culture of oocyte(s)/embryo(s), 4-7 days</p> <p>S4011 In vitro fertilization; including but not limited to identification and incubation of mature oocytes, fertilization with sperm, incubation of embryo(s), and subsequent visualization for determination</p> <p>S4015 Complete in vitro fertilization cycle, not otherwise specified, case rate</p> <p>S4016 Frozen in vitro fertilization cycle, case rate</p> <p>S4017 Incomplete cycle, treatment canceled prior to stimulation, case rate</p> <p>S4018 Frozen embryo transfer procedure canceled before transfer, case rate</p> <p>S4020 In vitro fertilization procedure canceled before aspiration, case rate</p> <p>S4021 In vitro fertilization procedure canceled after aspiration, case rate</p> <p>S4022 Assisted oocyte fertilization, case rate</p> <p>S4023 Donor egg cycle, incomplete, case rate</p> <p>S4025 Donor services for in vitro fertilization (sperm or embryo), case rate</p> <p>S4026 Procurement of donor sperm from sperm bank</p> <p>S4028 Microsurgical epididymal sperm aspiration (MESA)</p> <p>S4037 Cryopreserved embryo transfer, case rate</p> <p>Artificial insemination procedures are 58321 (intra-cervical) and 58322 (intra-uterine)</p> <p>58323: This code covers the process of preparing the sperm for insemination, including sperm washing and other techniques to isolate and concentrate sperm.</p> <p>58976: Gamete Intrafallopian Transfer (GIFT)</p>	Covered	Not Covered without Prior Authorization

		S4013 Complete cycle gamete intrafallopian transfer (GIFT) S4014 Complete cycle zygote intrafallopian transfer (ZIFT) Oocyte Retrieval: 58970 Ultrasonic Guidance: 76948 Ovum Transfer: 58976 Preparation of Embryo for Transfer: 89255 Sperm Injection (ICSI) are 89280 and 89281		
Office Visits other than Surrogacy Consultations	Evaluation & Management	CPT codes 99202-99205 or 99211-99215 for office visits	Not Covered	Not Covered
Emergency Care	Emergency Room & Emergency Physician	Rev 450-459; Physician 99281-99285	Not Covered	Not Covered
Urgent Care	Urgent Care facility or Physician Services, Ancillary Services	Rev 456, 516, 526 Physician 99202-99215	Not Covered	Not Covered
OB Ultrasounds	Radiology Services	76801, 76802, 76805, 76810, 76811, 76815, 76816, and 76817	Not Covered	Not Covered
Prenatal or Postnatal	Office Visits	9950, 99202-99215, 99421-99423	Not Covered	Not Covered
Mother Delivery	Room & Board Inpatient, Outpatient, Home	Rev Code 59400,59409,59510,59514,59610,59612,59618,59620	Not Covered	Not Covered
Any Inpatient Admissions or Inpatient Physician Services	Room and Board, physician services, or any other ancillary services	Rev Code 0100-0204 99221-99223, 99238- 99239, 99231-99233, 99234-99236, 99238-99239, G0316	Not Covered	Not Covered
Newborn Delivery	Inpatient Nursery Charges	Rev 170-179	Not Covered	Not Covered
Ambulance	Emergent or Non-Emergent Transportation	A0021-A0999	Not Covered	Not Covered
Any Other Services	Any other services not called out above	Misc	Not Covered	Not Covered