United Healthcare Community Plan

Gender Affirming Care (GAC)
Members < 18 years of age - Maryland
Attestation Request Form

Please complete this **entire** form and fax it to **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**
Start Date of the patient experiencing desired gender:	

Section D – Medication

Medication Name	Strength	Quantity	Directions for Use

Prescriber Attestation

ALL REQUESTS

□ **Yes** □ **No**	The patient is less than 18 years of age and has parental/guardian/care giver consent to make fully informed decision and consent to treatment. When consent involves a minor, parental consent will be required, and the current Maryland Minor Consent Laws will define who can consent for what services and providers' obligations.* * Maryland Code, Health-General § 20-102, https://health.maryland.gov/psych/pdfs/Treatment.pdf.)
□ **Yes** □ **No**	I am a Somatic Primary Care healthcare professional (Primary Care Provider as defined by COMAR 10.67.05.05A(5)) with a MD, PHD, DO, NP, or PA who has competencies in the assessment of transgender and gender diverse people seeking gender-related medical and surgical treatment, **OR** I am a mental health professional with a PhD, MD, EdD, DSc, DSW, PsyD, LCPC, or LCSW-C who has competencies in the assessment of transgender and gender diverse people seeking gender-related medical and surgical treatment.

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Member First Name:	Member Last Name:	Member DOB:

□ **Yes** □ **No**	**Adolescents:** The patient has a diagnosis of gender dysphoria or gender incongruence The patient's experience of gender incongruence is marked and sustained The patient has the desire to make their body as congruent as possible with a desired gender through surgery, hormone treatment or other medical therapies The gender incongruence causes clinically significant distress or impairment in social, occupational, or other important areas of functioning The gender incongruence is not a symptom of another medical disorder
□ **Yes** □ **No**	**Prior to gender affirming gonadal surgery** The patient must have experienced their desired gender for a minimum of 12 months of gender-affirming hormone therapy as appropriate to the person's gender goals before the person undergoes surgical intervention (unless hormone replacement therapy or gonadal suppression is not clinically indicated, the procedure is inconsistent with the patient's desires, goals, or expressions of individual gender identity or is medically contraindicated).
□ **Yes** □ **No**	The patient has no contraindicating somatic or mental health conditions that would impair their ability to participate in informed consent. In the situation where a patient has a mental health condition that interferes with their capacity to give informed consent and understand the risks, benefits, and alternatives to gender affirming treatment, the provider should facilitate treatment of the underlying condition to support the individual's ability to provide informed consent.
□ **Yes** □ **No**	The patient has the capacity to understand the effect of gender-affirming treatment on reproduction and has been versed in reproductive options prior to the initiation of gender-affirming surgeries that have the potential to create iatrogenic infertility.
□ **Yes** □ **No**	The patient has expressed full understanding of the psychological, social, and medical implications of treatment, for now and the future.

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge. UHC and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature.

Provider Signature: _____ **Date:** _____