Important Insurance & Documentation Notice — New Clients

To help secure insurance coverage for your electrolysis, **our clinic will submit the Prior Authorization request on your behalf.**

Washington State law protects your right to gender-affirming care:

- **Senate Bill 5313 (2019):** Requires WA health plans to cover treatments for gender dysphoria, including medically necessary hair removal.
- **Gender-Affirming Care Shield Law:** Prohibits insurers from excluding or discriminating against coverage based on gender identity.

What We Need From You

To complete your Prior Authorization request, please provide us with the following:

- Insurance Card
- DOB

Always Required:	
1. Clinical Diagnosis of Gender Dysphoria	Letter or record from a licensed provider (MD, NP, PA, psychiatrist, psychologist, LCSW, LMHC) including DSM-5 reference, date of diagnosis, and signature.
2. Proof of Medical Necessity	Letter or clinical notes from provider explaining why electrolysis is needed as part of gender-affirming care. Must be on official letterhead.
Sometimes Required by Insurers:	
3. Evidence of ≥6 Months of Hormone Therapy	Lab reports or prescription records signed by prescribing clinician.
4. Evidence of ≥6 Months in Gender Role	Letter or affidavit from a licensed provider confirming you have been living full-time in your affirmed gender role for at least 6 months.

Documentation Standards

- Must be on official letterhead or prescription pad
- Must include provider's name, license number, and signature
- Must reference your name and relevant dates

What We'll Do for You

- We will prepare and submit the Prior Authorization form to your insurance provider.
- We'll include the required billing codes:
- ICD-10 (Diagnosis): F64.0 — Gender dysphoria
- CPT (Procedure): 17380 — Electrolysis epilation
- POS (Place of Service): 11 — Office

• We’ll follow up with your insurer if more information is requested.

Important Insurance Limitation

Medicaid, Medicare, and Apple Health plans do not cover electrolysis services at our clinic. This is because these programs require providers to be directly contracted with the state or federal system, and they do not reimburse out-of-network clinics or allow retroactive reimbursement through superbills. Unfortunately, this is a payer limitation, not a reflection of medical necessity.

Important Note

Prior authorization does **not** guarantee payment. Final coverage depends on your plan’s benefits, deductibles, and policy limits. Providing complete documentation helps avoid delays or denials.

Need Assistance?

We know this process can feel overwhelming. Our team is here to help at every step.

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