

Capsule Endoscopy Precertification Information Request Form

Applies to:

Aetna plans

Innovation Health® plans

Health benefits and health insurance plans offered, underwritten, and/or administered by the following:

Allina Health and Aetna Health Insurance Company (Allina Health | Aetna)

Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner | Aetna)

Sutter Health and Aetna Administrative Services LLC (Sutter Health | Aetna)

Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance Company (Texas Health Aetna)

aetna®

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services on behalf of its affiliates.

Capsule Endoscopy Precertification Information Request Form

About this form

You can't use this form to initiate a precertification request. To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically. **Failure to complete this form and submit all of the medical records we are requesting may result in the delay of review.**

Effective **May 24, 2018**, this form replaces all other capsule endoscopy precertification information request documents and forms. This form will help you supply the right information with your precertification request. You don't have to use the form. But it will help us adjudicate your request more quickly.

How to fill out this form

As the patient's attending physician, you must complete all sections of the form.

You can use this form with all Aetna health plans, including Aetna's Medicare Advantage plans. You can also use this form with health plans for which Aetna provides certain management services.

When you're done

Once you've filled out the form, submit it and all requested medical documentation to our Precertification Department by:

- **(Preferred)** Upload your information electronically on our secure provider website on NaviNet® at **connect.navinet.net**.
 - Complete a Precertification Inquiry transaction for the patient.
 - When the inquiry is successful, click the "Add Attachment" link in the upper right corner of the screen.
 - Upload your document(s) and click "Attach." The window will close and you will return to Precert Inquiry screen.
- Send your information via confidential fax to:
 - Precertification – Commercial Plans: **859-455-8650**
 - Precertification - Medicare Advantage Standard Organization Determination: **859-455-8650**
 - Precertification - Medicare Advantage (expedited only): **860-754-5468**
- Mail your information to: **PO Box 14079**
Lexington, KY 40512-4079

What happens next?

Once we receive the requested documentation, we'll perform a clinical review. Then we'll make a coverage determination and let you know our decision. Your administrative reference number will be on the electronic precertification response.

How we make coverage determinations

If you request precertification for a Medicare Advantage member, we use CMS benefit policies, including national coverage determinations (NCD) and local coverage determinations (LCD) when available, to make our coverage determinations. If there isn't an available NCD or LCD to review, then we'll use the Clinical Policy Bulletin referenced below to make the determination.

For all other members, we encourage you to review **Clinical Policy Bulletin #588: Capsule Endoscopy** before you complete this form.

You can find the Clinical Policy Bulletins and Precertification Lists by visiting the website on the back of the member's ID card.

Questions?

If you have any questions about how to fill out the form or our precertification process, call us at:

- HMO plans: **1-800-624-0756**
- Traditional plans: **1-888-632-3862**

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Section 1: Provide the following general information

Member name:	Administrative reference number (required):
Member ID:	Member date of birth:
Requesting provider/facility name:	
Requesting provider/facility NPI:	
Requesting provider/facility phone number: 1- - -	
Requesting provider/facility fax number: 1- - -	
Assistant/co-surgeon name (if applicable):	TIN:

Section 2: Select the capsule endoscopy indication that applies to your patient. Then choose the appropriate answer for each corresponding question, where applicable.

Evaluation of locoregional carcinoid tumors of the small bowel in persons with carcinoid syndrome

Evaluation of persons with celiac disease who are unable to undergo esophagogastroduodenoscopy (EGD)

- Serology results: Positive Negative
- Biopsy: Positive Negative

Initial diagnosis in persons with suspected Crohn's disease, in a patient with:

- Abdominal pain
- Diarrhea
- Signs of inflammation without evidence of disease on conventional diagnostic tests, including small-bowel follow-through or abdominal CT scan/CT enterography and upper and lower endoscopy (EGD and colonoscopy):

<input type="checkbox"/> Fever	<input type="checkbox"/> Elevated erythrocyte sedimentation rate
<input type="checkbox"/> Elevated white blood cell count	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Elevated C reactive protein	

Re-evaluation of persons with celiac disease or Crohn's disease who remain symptomatic despite treatment and there is not suspected or confirmed gastrointestinal obstruction, stricture, or fistulae.

Investigating suspected small intestinal bleeding in persons with objective evidence of recurrent, obscure gastrointestinal bleeding (e.g., iron-deficiency anemia and positive fecal occult blood test, or visible bleeding) who have had upper and lower gastrointestinal endoscopies within the past 12 months (EGD and colonoscopy) that have failed to identify a bleeding source:

- Does the patient have visible bleeding? Yes No
- Is there documentation of iron-deficiency anemia? Yes No
- Date of last EGD: / / Date of last Colonoscopy: / /

For surveillance of small intestinal tumors in persons with one of the following:

- Lynch syndrome
- Peutz-Jeghers syndrome
- Other polyposis syndromes affecting the small bowel

For screening or surveillance of esophageal varices in cirrhotic persons with significantly compromised liver function (i.e., Child-Pugh score of Class B or greater)

Standard upper endoscopy with sedation or anesthesia is contraindicated

- Specify reason for contraindication:

Other; Please specify:

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Section 3: Provide the following documentation for your request

- Current history and physical
- Office notes related to the member's condition for which treatment is proposed
- Description of proposed treatment
- Conventional diagnostic tests, as applicable, such as small-bowel follow-through, abdominal CT scan/CT enterography, EGD, colonoscopy, biopsy reports
- Laboratory tests, as applicable, documenting anemia, elevated sedimentation rate, elevated white blood cell count, serology reports
- Medical records supporting the indications you selected in Section 2.

Section 4: Read this important information

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Section 5: Sign the form

Just remember: You can't use this form to initiate a precertification request. To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically.

Signature of treating doctor or other qualified healthcare provider:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -