Infertility Services
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)

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About this form

Effective **May 31, 2018**, this form replaces all other Infertility Services precertification information request documents and forms.
Failure to complete this form and submit all of the medical records we are requesting may result in the delay of review.

Once completed, this form contains confidential information. Only the individual or entity it's addressed to can use it. If you're not the intended recipient, or the employee or agent responsible for delivering the form to the intended recipient, you can't disseminate, distribute or copy the completed form. If you received the completed form in error, call us at **1-800-575-5999**.

How to fill out this form

As the patient's attending physician, you must complete Sections 2 through 7 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 by confidential fax to 1-(866) 488-9429

- Mail your information to: **PO Box 14079**
  Lexington, KY 40512-4079

What happens next?

Once we receive the requested documentation, we will perform a clinical review. Then we'll make a coverage determination and let you know our decision.

How we make coverage determinations

The Clinical Policy Bulletins referenced will be used as a resource in decision making. We encourage you to review **Clinical Policy Bulletin #327: Infertility** and **Clinical Policy Bulletin #358: Invasive Prenatal Diagnosis of Genetic Diseases,** 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.

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Fax to: Infertility Department	**Fax number:** 1-866-488-9429	**Today's Date:** / /

Section 1: To be completed by the Precertification Department or Ordering Physician

Member name:	
Member ID:	**Member date of birth:** / /
Requesting Provider and/or group name:	
Provider or group TIN or NPI:	**Provider or group fax number:** 1-
Contact name of office personnel to call with questions:	**Telephone number (with extension):** - - ext.

We've received a coverage request for infertility services for the above member. Your reference number for this request is . **This is not an approval.** Your request requires clinical review and a decision is pending. We'll contact your office/facility once we make a coverage determination.

Section 2: Treatment Plan

(Request for precertification can be started once treatment plan is known following negative pregnancy test or start of menses)

Requested service:

- ☐ Injectable Timed Intercourse Medication used:
- ☐ Intrauterine Insemination (IUI) Medication used:
- ☐ Invitro Fertilization (IVF)
- ☐ Fertility Preservation Invitro Fertilization cycle
- ☐ Assisted Hatching (AH)
- ☐ Intra-cytoplasmic Sperm Injection (ICSI)
- ☐ Frozen Embryo Transfer (FET)
- ☐ Pre-Implantation Genetic Diagnosis (PGD)
- ☐ Other (please specify)

Start date of cycle: / /	**Donor sperm:** ☐ Yes ☐ No **Donor eggs:** ☐ Yes ☐ No

Section 3: Member's Clinical History
(SUBMIT APPLICABLE CLINICAL RECORDS)

Date of last menstrual period (LMP): / /

FSH Level*: **E2 level*:** **AMH level*:** ***Please submit lab work***

Date collected: / /

Was member on medication(s) when blood work was drawn? ☐ Yes ☐ No

If yes, list medication(s):

Has either partner ever had a voluntary sterilization? ☐ Yes ☐ No

If yes:

☐ Male **or** ☐ Female

Has there been a reversal? ☐ Yes ☐ No

Date of reversal: / /

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Member name:	**Member ID:**

Section 4: Tubal Factor Infertility

Is there a history of tubal factor infertility? ☐ Yes ☐ No

If yes, please complete the following:

Date HSG performed: / / Findings:

If findings on HSG are abnormal, please submit HSG report

History of Endometriosis (submit operative report): ☐ Yes ☐ No

History of pelvic surgery (submit operative report): ☐ Yes ☐ No

History of Ectopic pregnancy following Infertility treatment (submit clinical records regarding treatment cycle that resulted in ectopic pregnancy): ☐ Yes ☐ No

History of Ovarian hyperstimulation (submit lab and ultrasound reports): ☐ Yes ☐ No

Section 5: Male Factor Infertility

Is there a history of male factor infertility? ☐ Yes ☐ No

Semen analysis (SA): For consideration of Male factor and ICSI, please submit two (2) SAs performed at least 14 days apart

Section 6: Infertility Treatment History

Is there a history of infertility treatment? ☐ Yes ☐ No

If yes, submit treatment records and complete the following:

OI and/or IUI Cycle history: ☐ Yes ☐ No

Date(s):

IVF Cycle history: ☐ Yes ☐ No

Date(s):

Are there any embryo's currently in storage?

FET Cycle history: ☐ Yes ☐ No

Date(s):

Are there any embryo's currently in storage?

Section 7: 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 8: Sign the form

Your signature:

Today's date: / /