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)

aetna®

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About this form

Effective **August 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 Address:**
Provider or group TIN: **and 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:
- ☐ Pre-Implantation Genetic Screening (PGS)
- ☐ Pre-Implantation Genetic Diagnosis (PGD) **Please submit genetic testing results with this request**
- ☐ Invitro Fertilization (IVF)
- ☐ Assisted Hatching (AH)
- ☐ Intra-cytoplasmic Sperm Injection (ICSI)
- ☐ Frozen Embryo Transfer (FET)
- ☐ Other (please specify)

Start date of cycle: / /	**Donor sperm:** ☐ Yes ☐ No **Donor eggs:** ☐ Yes ☐ No
Date of last menstrual period (LMP): / /	

Section 3: Member's Clinical History
Please have a clinician complete the following

FSH Level: **E2 level:**
Date collected: / /
Was member on medication(s) when blood work was drawn? ☐ Yes ☐ No
If yes, list medication(s):

Section 4: Provide ONLY the following documentation for your request

- **OI, IUI, and timed intercourse cycles**: Submit only LMP, start date, medication to be used (if any), and day three (3) blood work
- **Initial ART Cycle:** Submit indication for IVF/FET (i.e., severe male factor, previous ovulation induction cycles without pregnancy, stage IV endometriosis)
- **Additional ART cycle requests:** Submit only LMP, start date, day three (3) bloodwork, and complete #5 below in Section 5 for previous ART cycles

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Section 5: Advanced Reproductive Technology (ART) Requests

1. **Completion of previous ovulation induction (OI) cycles:** Please do not send cycle sheets unless specifically requested.

Cycle #	Medication taken for OI Cycle	Month/Year Completed
1		
2		
3		
4		
5		
6		

2. **Endometriosis or pelvic surgeries:** Submit the operative report

3. **Tubal factor:** A hysterosalpingogram (HSG) is required. Submit the HSG with dye report. Do not include Sono HSG or Femvue.
   History of ectopic pregnancy during infertility treatment: ☐ Yes ☐ No

4. **Male factor:** Submit two (2) abnormal semen analyses at least two (2) weeks apart. May include sperm prep reports.

5. **Previous ART cycles: Fill in below for each ART cycle.**

IVF		
Retrieval date: / /	Retrieval date: / /	Retrieval date: / /
# of oocytes retrieved:	# of oocytes retrieved:	# of oocytes retrieved:
# of oocytes with conventional insemination:	# of oocytes with conventional insemination:	# of oocytes with conventional insemination:
# of oocytes with ICSI:	# of oocytes with ICSI:	# of oocytes with ICSI:
# of oocytes fertilized:	# of oocytes fertilized:	# of oocytes fertilized:
# of embryos transferred:	# of embryos transferred:	# of embryos transferred:
# of embryos cryopreserved:	# of embryos cryopreserved:	# of embryos cryopreserved:
# of embryos biopsied for PGD/PGS testing:	# of embryos biopsied for PGD/PGS testing:	# of embryos biopsied for PGD/PGS testing:
Results of PGD/PGS:	Results of PGD/PGS:	Results of PGD/PGS:

FET		
Transfer date: / /	Transfer date: / /	Transfer date: / /
# of embryos thawed:	# of embryos thawed:	# of embryos thawed:
# of embryos transferred:	# of embryos transferred:	# of embryos transferred:
# of embryos still frozen:	# of embryos still frozen:	# of embryos still frozen:

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Section 6: 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 7: Sign the form	
Your signature:	
Today's date: / /	