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)

About this form

This form replaces all other precertification information request documents and forms. **Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage. Please do not retain this form in your files. This form is subject to frequent change.**

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 **1-800-624-0756** or **1-888-632-3862**.

How to fill out this form

As the patient's attending physician, you must complete Sections 2 through 6 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:

- We prefer you submit precertification requests electronically. Use our provider portal on Availity® to also upload clinical documentation, check statuses, and make changes to existing requests. **Register for Availity at www.availity.com or learn more about Availity at www.availity.com/aetnatraining**
- Send your information via confidential fax: Precertification – Commercial and Medicare (including **expedited**) using FaxHub: **833-596-0339**.
  - The fax number above (FaxHub) is for clinical information only. Please send specific information that supports your medical necessity review. Please continue to send all other information (claims etc) to appropriate fax numbers.
- 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

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 is not an available NCD or LCD to review, then the Clinical Policy Bulletin referenced below will be used as a resource in decision making.

For all other members, we encourage you to review **Clinical Policy Bulletins** before completing 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.

Precertification Information Request Form

Fax to: Precertification Department	**Fax number:** 1-833-596-0339
Section 1: To be completed by the Precertification Department	
Member name:	
Member Phone Number:	
Member ID:	**Member date of birth:**
Reference number:	
If you do not have a reference number, DO NOT use this form. Please submit your request electronically through Availity at www.availity.com or call 888-632-3862 or 1-800-624-0756 to initiate precertification.	
Physician name:	**Physician NPI:**
Physician fax number: 1-	**Physician status:** ☐ Participating ☐ Non-participating
Office phone number: 1-	**Requestor phone number:** 1-
Section 2: Provide the following general information	
Facility name:	
Facility fax number: 1-	**Facility status:** ☐ Participating ☐ Non-participating
Assistant/Co-surgeon name and TIN (if applicable):	
Date of procedure: / /	
Diagnosis code(s):	
CPT/HCPCS codes, with descriptions, which best describe the service(s) you'll provide. (For drugs/injectables, include any administration codes.)	

Precertification Information Request Form

Fax to: Precertification Department	**Fax number:** 1-833-596-0339
Member name:	
Member Phone Number:	
Member ID:	**Reference number:**

Section 3: Provide the following patient-specific information

The patient's symptoms

A description of your clinical findings for this patient

Any conservative management, with outcome, related to this patient's condition

The anticipated outcome of the proposed treatment

Any additional details to be considered for this request

Are you requesting a hospital admission greater than 24 hours? ☐ Yes ☐ No
Provide clinical rationale for inpatient hospitalization:

Section 4: For Inpatient stays post hip arthroplasty and Total knee

What is the patient's expected length of stay?
Is the patient's body mass index (BMI) greater than 40? ☐ Yes ☐ No
Does the patient have chronic obstruction pulmonary disease (COPD) on is oxygen therapy? ☐ Yes ☐ No
Does the patient have end stage renal disease (ESRD) and is undergoing regularly scheduled dialysis? ☐ Yes ☐ No
Has the patient had a recent (within the past 3 months) cardiac event: ☐ Yes ☐ No

a. Heart attack/myocardial infarction (MI) ☐
b. Stroke/cerebrovascular accident (CVA) ☐
c. Mini stroke/transient ischemic attack (TIA) ☐

Section 5: For Dialysis at a non-participating facility only

Is member using their out of network benefit? ☐ Yes ☐ No If yes, refer to section 7.

Are you requesting a higher benefit level review? ☐ Yes ☐ No If yes, refer to section 5.

Section 6: Provide the following patient-specific information for non-participating provider request at a higher benefit level

Note: A member case must exist with a reference number. Coverage for these requests are generally not available if a participating provider is available. Please call Member or Provider Services (as applicable) to help locate a participating provider.

Is there a medical reason the member needs to see the non-participating provider: ☐ Yes ☐ No
What is the reason:

Precertification Information Request Form

Fax to: Precertification Department	**Fax number:** 1-833-596-0339
Member name:	
Member Phone Number:	
Member ID:	**Reference number:**

Section 7: Requests for out of network providers

Will the member be using out of network benefits: ☐ Yes ☐ No

Have you seen this provider before: ☐ Yes ☐ No
If yes, dates of visits:
If yes, what type of treatment or services were performed:
If no, what type of treatment or services are being requested (office visit, initial consult or any procedure/services):

Have services with the non-participating provider started: ☐ Yes ☐ No
If so, when:

Is the requested service scheduled: ☐ Yes ☐ No
If yes, what date:

Who referred you to this provider? (PCP, participating attending, follow-up to ER, follow-up to hospital admission or self-referred [for member]):
Referring physician name:
Phone #:
Fax #:

Section 8: Provide the following documentation for your request

☐ Current history and physical
☐ Office notes related to the member's condition for which treatment is proposed
☐ Provide specific office notes to support need for hospitalization
☐ Description of proposed treatment
☐ Lab/pathology and x-ray reports, if applicable

For DME:
- ☐ Product description(s)
- ☐ Detailed usage instructions

For potential experimental/investigational procedures:
- ☐ FDA or applicable medical society position
- ☐ Published medical literature to support the procedure or item's use in the treatment of the member's diagnosis

For cosmetic procedures:
- ☐ Photographic documentation or patient's condition, if applicable

Section 9: 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 10: Sign the form

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:
Telephone number: 1-