

**Proton Beam Radiotherapy
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®

Proton Beam Radiotherapy 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 31, 2018**, this form replaces all other Proton Beam Radiotherapy 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 #270: Proton Beam and Neutron Beam Radiotherapy** 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: Provide the following patient-specific information.

Select the diagnosis that applies to your patient:

Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases

Radiosensitive malignancy in children (21 years of age and younger)

Uveal melanomas confined to the globe (i.e., not distant metastases)

Other, please specify

Does the patient have any distant metastatic disease? Yes No
 If yes, please explain and provide location of the metastasis

Does the patient have any history of previous radiation therapy treatment? Yes No
 If yes, please provide the following:
 Date(s):
 Type(s):
 Dose(s):

Is the patient being considered for inclusion in a clinical trial of proton beam radiotherapy for this condition?
 Yes If yes, please explain in detail.
 No

Please explain the current proton beam radiotherapy treatment intent (i.e., curative, palliative or in lieu of other radiation modalities for which the member may not tolerate based on their current clinical condition).

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Section 3: Provide the following documentation for your request

- Current history and physical
- Medical records related to the patient's condition for the proposed treatment, including the following:
 - Detailed radiation treatment plan
 - Documentation of all clinical findings
 - Type, duration and outcome of any prior surgical or radiotherapy treatment
- All radiology and imaging reports documenting the presence or absence of metastatic disease

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.

Form completed by:

Title:

Signature of treating doctor or other qualified healthcare provider:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -