

**Wheelchairs and Power Operated Vehicles  
(Scooters)  
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®**

# Wheelchairs and Power Operated Vehicles (Scooters) 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 Wheelchairs and Power Operated Vehicles (Scooters) 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 #271: Wheelchairs and Power Operated Vehicles (Scooters)**, 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	
<b>Member name:</b>	<b>Administrative reference number (required):</b>
<b>Member ID:</b>	<b>Member date of birth:</b>
<b>Requesting provider/facility name:</b>	
<b>Requesting provider/facility NPI:</b>	
<b>Requesting provider/facility phone number:</b> 1-    -    -	
<b>Requesting provider/facility fax number:</b> 1-    -    -	
<b>Assistant/co-surgeon name (if applicable):</b>	<b>TIN:</b>
Section 2: Provide the following patient-specific information	
Does the patient have a mobility limitation that significantly impairs the ability to participate in one or more mobility-related activities of daily living (MRADLs) (e.g., toileting, feeding, dressing, grooming, bathing) in customary locations in the home that would be alleviated by the requested mobility device? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient ambulatory? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many feet can the patient ambulate with and without an assistive device (e.g., cane or walker)?	
Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is it anticipated the patient's condition will not resolve within 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient able to self-propel a manual wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please document why the patient is unable to self-propel.	
Has the patient shown the ability to safely operate the requested mobility device? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient's home provide adequate access between rooms, maneuvering space and surfaces for the operation of the requested device? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the requested device for use primarily outside the patient's home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient currently own a wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the following information about the current wheelchair: <div style="margin-left: 20px;"> <input type="checkbox"/> Manual    <input type="checkbox"/> Power operated              Specify the features on the power wheelchair              <input type="checkbox"/> Tilt    <input type="checkbox"/> Recline    <input type="checkbox"/> Power legs    <input type="checkbox"/> Seat Elevator              <input type="checkbox"/> Other, please specify         </div>	
Specify the age of the current wheelchair Detailed list of repairs, including cost, needed for the current wheelchair:	
Explain why the current device is not adequate to meet the patient's needs:	

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### Section 2 Continued: Provide the following patient-specific information

<input type="checkbox"/> Adjustable arm-height option	<input type="checkbox"/> Enhanced joystick	<input type="checkbox"/> Mechanical linked leg elevation feature	<input type="checkbox"/> Power tilt and/or recline seating systems	<input type="checkbox"/> Side guard
<input type="checkbox"/> Anti-rollback device and anti-tip device	<input type="checkbox"/> Gear reduction drive wheel	<input type="checkbox"/> Non-powered or powered seat elevator or standing device	<input type="checkbox"/> Power wheelchair drive control systems	<input type="checkbox"/> Solid seat insert or other custom seating option(s)
<input type="checkbox"/> Arm trough	<input type="checkbox"/> Headrest	<input type="checkbox"/> Non-standard seat width, depth, or height	<input type="checkbox"/> Push-rim activated power assist device	<input type="checkbox"/> Swingaway retractable, or removable hardware
<input type="checkbox"/> Batteries: U-1 battery, 22 NF deep-cycle lead acid battery, gel battery or Group 24 battery	<input type="checkbox"/> Lap tray wheelchair attachment	<input type="checkbox"/> One-arm drive attachment	<input type="checkbox"/> Reinforced back upholstery or reinforced seat upholstery	<input type="checkbox"/> Tilt-in-space
<input type="checkbox"/> Chin control	<input type="checkbox"/> Lever activated wheel drive	<input type="checkbox"/> Power add-ons to manual wheelchairs	<input type="checkbox"/> Safety belt/pelvic strap	
<input type="checkbox"/> Electronic interface control lights or other electrical devices	<input type="checkbox"/> Manual fully reclining back option	<input type="checkbox"/> Power leg elevation feature	<input type="checkbox"/> Semi-reclining back option	
<input type="checkbox"/> Elevating leg rests	<input type="checkbox"/> Mechanical or power shear reduction features	<input type="checkbox"/> Power stander attachment	<input type="checkbox"/> Shoe holder	

### Section 3: Provide the following documentation for your request

- Itemized invoice for the requested mobility device and all accessories
- Current history and physical
- Current evaluation from the durable medical equipment (DME) vendor for the requested mobility device

### 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-        -        -