Breast Reduction and/or Reconstructive Surgery 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 is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services on behalf of its affiliates.

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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 medical records we are requesting may result in the delay of review or denial of coverage.**

This form replaces all other breast reduction surgery 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 portal at **www.Availity.com**.
- Email requests that require photographs to:
  - Commercial Plans: **VFAXPrecert@aetna.com**
  - Medicare Advantage Plans: **MedicarePrecert@aetna.com**
- Send your information via confidential fax to: Precertification – Commercial and Medicare (including **expedited**) using FaxHub: **1-833-596-0339.**

  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. Thank you.
- Mail your clinical 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 #17: Breast Reduction Surgery and Gynecomastia Surgery** 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 **If submitting request electronically, complete member name, ID and reference number only.**	
Member name:	**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 for BREAST REDUCTION surgery

Has the patient had persistent symptoms in at least 2 body areas that have affected their daily activities for at least 1 year? ☐ Yes ☐ No

If yes, select the body areas/symptoms:

- ☐ Upper back
- ☐ Neck
- ☐ Shoulders
- ☐ Upper extremity parasthesias
- ☐ Other (list):
- ☐ Headaches
- ☐ Painful kyphosis, documented by x-rays
- ☐ Pain, discomfort and/or ulceration from bra straps cutting into shoulders
- ☐ Skin breakdown from overlying breast tissue

Patient's current: Height: Weight:

List the amount of breast tissue (not fatty tissue), in grams, to be removed from each breast.

☐ Left breast: ☐ Right breast:

Section 3: Provide the following patient-specific information for BREAST RECONSTRUCTION surgery

Describe the planned procedure:

Describe any previous breast surgeries:

Reason for implant removal and/or reinsertion:

Is this a staged procedure? ☐ Yes ☐ No

If yes, please describe the stages, including the date(s) of the procedure(s):

GR-68829-2 (5-20)

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Member name:	Member ID:
Reference number (required):	Member date of birth:

Section 4: Provide the following documentation for your request

- Current history and physical
- Lab/pathology and radiology reports, if applicable
- Any supporting medical records documenting clinical findings, conservative management with outcome, and current plan of care.
- Submit the following clinical documentation for **breast reduction surgery only**:
  - Clinical information documenting symptoms and type, length and outcome of treatment rendered
  - Most recent mammogram report for patients 50 years of age and older. (The patient **must** have received the mammography within two (2) years prior to the date of the planned reduction mammoplasty.)

    Date of mammography: / /
  - Photographs confirming severe breast hypertrophy
  - Evaluation by a physician, who has determined the following:
    - The patient's symptoms are due primarily to macromastia,
    - The procedure is likely to result in improvement of chronic pain, and
  - Pain symptoms persist despite at least a 3-month trial of therapeutic measures such as supportive devices, analgesic/NSAIDs interventions, and physical therapy/exercises/posturing maneuvers.

Section 5: 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 6: 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 person completing form:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -