Gender Affirming 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)

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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 submit your request electronically. Or you can call our Precertification Department **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 gender affirming 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

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 today at **availity.com/aetnaproviders** or learn more about Availity at **www.availity.com/aetnatraining**.

- Precertification- Commercial and Medicare 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.
- 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 #615: Gender Affirming 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**
- **Medicare plans: 1-800-624-0756**

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Section 1: Member Demographics If submitting request electronically, complete member name, ID and reference number only.	
Member name:	**Reference number (required):**
Member ID:	**Member date of birth:**
Member Phone Number:	**Was the member:** ☐ Assigned female at birth ☐ Assigned male at birth

Section 2: Provider Information		
Name:	**NPI:**	**Billing TIN:**
Phone number: - -	**Fax number:** 1- - -	
Address:		
Is provider participating? ☐ Yes ☐ No		

Section 3: Facility Information		
Name:	**NPI:**	**TIN:**
Phone number: - -	**Fax number:** 1- - -	
Address:		
Is facility participating? ☐ Yes ☐ No		

Section 4: Assistant/Co-Surgeon Provider Information		
Name:	**NPI:**	**TIN:**
Phone number: - -	**Fax number:** 1- - -	
Address:		
Is provider participating? ☐ Yes ☐ No	**Is provider assistant surgeon?** ☐ Yes ☐ No	**Is provider co-surgeon?** ☐ Yes ☐ No

Section 5: Place of Service
Will the procedure be performed: ☐ Inpatient; Bed Days Requested: **Complete Section 10 if request is for outpatient**

Section 6: Required Documentation – *Submit the following documentation with this form* **Omitting required documentation may delay our decision**
Office notes related to the member's condition. *The notes should include a description of the proposed treatment and hormone therapy and duration, if applicable.*
Signed Behavioral referral letter(s) from a qualified mental health professional. *The letters must be **signed** and document persistent gender dysphoria, any significant medical or mental health concerns, and that the member can make a fully informed decision and consent for treatment.*

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Member name:	
Member ID:	**Reference Number:**

Section 7: Services – Select from the list below

Scheduled Procedure Date: ***This is not an approval.*** Your request requires clinical review and a decision is pending.

Services Requested:	**# Mental Health Professional Referral Letters**
☐ **Genital Reconstruction** (*vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, placement of a testicular prosthesis and erectile prosthesis, penectomy, vaginoplasty, labiaplasty, and/or clitoroplasty)*	**2**
☐ **Gonadectomy** (*hysterectomy, oophorectomy or orchiectomy*)	**2**
☐ **Hair Removal** (*electrolysis or laser*) at surgical or graft site	**1**
☐ **Top Surgery** (*breast removal or augmentation*)	**1**

Write in any services requested that are not listed above:

Section 8: Diagnosis, Procedures Requested

Diagnosis Codes:		
CPT\HCPCS Code	Description	Number of units/services

Member name:	
Member ID:	**Reference Number:**

Section 9: Site of Service Information

If procedure to be performed outpatient indicate the setting:

- ☐ Outpatient hospital
- ☐ Ambulatory Surgical Center (free standing)
- ☐ Office

If request is for o*utpatient hospital* check any/all that apply:

- ☐ Less than 12 years of age
- ☐ American Society of Anesthesiologists (ASA) Physical Status classification III or higher
- ☐ Danger of airway compromise
- ☐ Morbid obesity (BMI > 35 with comorbidities or BMI > 40)
- ☐ Pregnant
- ☐ Advanced liver disease
- ☐ Poorly controlled diabetes (hemoglobin A1C > 7)
- ☐ End stage renal disease (ESRD) with hyperkalemia ☐ or undergoing dialysis ☐
- ☐ Active substance use related disorders (Includes alcohol dependence and/or current use of high dose opioids).

High risk cardiac status:

- ☐ Myocardial infarction in last 90 days
- ☐ Ongoing symptoms from previous MI
- ☐ Significant heart valve disease
- ☐ Symptomatic cardiac arrhythmia
- ☐ Hypertension resistant to 3 or more medications
- ☐ Uncompensated chronic heart failure

Coronary artery disease (CAD) or peripheral vascular disease (PVD) with:

- ☐ Ongoing ischemia or recent MI/angioplasty PCI
- ☐ Drug Eluting Stent (DES) Bare Metal Stent placed in last year
- ☐ Angioplasty in last 90 days
- ☐ Current use of Aspirin or prescription anticoagulants

Comorbid neurological or neuromuscular condition

- ☐ Stroke/cerebrovascular accident (CVA)
- ☐ Mini stroke/transient ischemic attack (TIA)
- ☐ Uncontrolled epilepsy
- ☐ Cerebral palsy
- ☐ Multiple Sclerosis
- ☐ Amyotrophic lateral sclerosis
- ☐ Traumatic brain injury with significant cognitive or behavioral issues
- ☐ Muscular dystrophy

Respiratory conditions:

- ☐ Moderate to severe obstructive sleep apnea

Unstable respiratory status:

- ☐ Poorly controlled asthma (FEV1 < 80% despite medical management)
- ☐ COPD or
- ☐ Ventilator dependent patient

Continued

Member name:	
Member ID:	**Reference Number:**

Section 9, continued: Site of Service Information

Bleeding or clotting disorders or conditions:

- ☐ Requiring replacement factor, blood products or special infusion products to correct a coagulation defect
- ☐ Thrombocytopenia (platelet <100,000/microL)
- ☐ Anticipated need for blood or blood product transfusion
- ☐ Sickle cell disease
- ☐ History of Disseminated Intravascular Coagulation (DIC)

☐ Personal or family history of complication of anesthesia

☐ History of solid organ transplant requiring anti-rejection medication(s)

☐ Other unstable or severe systemic diseases, intellectual disabilities or mental health conditions that would be best managed in an outpatient hospital setting

☐ This will be a prolonged surgery (>3 hrs.)

Do any of the following apply when procedure(s) to be performed at **outpatient hospital setting**:

☐ The required operative equipment is not available at a participating free-standing ambulatory surgical center or office based surgical center

List specific equipment not available:

☐ There are no participating general or specialty free-standing ambulatory surgical centers or office based surgical centers that allow procedure(s) planned

Section 10: 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 11: 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- - -