

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)



Precertification Information Request Form

About this form

Do not use this form to initiate a precertification request. To initiate a request, submit electronically on Availity or call our Precertification Department. Submit your medical records to support the request with your electronic submission.

We've made it easy for you to authorize services and submit any requested clinical information. Just use our provider portal on Availity®. Register today at [Availity.com/aetnaproviders](https://www.availity.com/aetnaproviders). Once your account is ready, you can start submitting authorization requests right away.

- For additional information on Availity, go to <https://www.aetna.com/health-care-professionals/resource-center/availity.html>

Requesting authorizations on Availity is a simple two-step process

Here's how it works:

1. Submit your initial request on Availity with the Authorization (Precertification) Add transaction.
2. Then complete a short questionnaire, if asked, to give us more clinical information.
 - If you receive a pended response, then complete this form and attach it to the case electronically.

This form will help you supply the right information with your precertification request. Typed responses are preferred. Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.

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:

- If your request was submitted via telephone, you can either:
 - Access our provider portal via Availity; enter the Reference number provided and attach this form and all requested medical documentation to the case or
 - Send your information by confidential fax to:
 - **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.
 - If you do not have fax or electronic means to submit clinical:
 - Mail your information to: **PO Box 14079**
Lexington, KY 40512-4079
(Please note mailing will add to the review response time)

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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 Bulletins** 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 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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Fax to: Precertification Department	Fax number: 1-833-596-0339
Section 1: Provide the following general information for all requests	
Typed responses are preferred. If the responses cannot be typed, they should be printed clearly	
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: <input type="checkbox"/> Participating <input type="checkbox"/> 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: <input type="checkbox"/> Participating <input type="checkbox"/> 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.)	

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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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have chronic obstruction pulmonary disease (COPD) on is oxygen therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have end stage renal disease (ESRD) <u>and</u> is undergoing regularly scheduled dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a recent (within the past 3 months) cardiac event: <input type="checkbox"/> Yes <input type="checkbox"/> No a. Heart attack/myocardial infarction (MI) <input type="checkbox"/> b. Stroke/cerebrovascular accident (CVA) <input type="checkbox"/> c. Mini stroke/transient ischemic attack (TIA) <input type="checkbox"/>	
Section 5: For Dialysis at a non-participating facility only	
Is member using their out of network benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, refer to section 7.	
Are you requesting a higher benefit level review? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No What is the reason:	

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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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you seen this provider before: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, when:	
Is the requested service scheduled: <input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/> Current history and physical	
<input type="checkbox"/> Office notes related to the member's condition for which treatment is proposed	
<input type="checkbox"/> Provide specific office notes to support need for hospitalization	
<input type="checkbox"/> Description of proposed treatment	
<input type="checkbox"/> Lab/pathology and x-ray reports, if applicable	
For DME:	
<input type="checkbox"/> Product description(s)	
<input type="checkbox"/> Detailed usage instructions	
For potential experimental/investigational procedures:	
<input type="checkbox"/> FDA or applicable medical society position	
<input type="checkbox"/> Published medical literature to support the procedure or item's use in the treatment of the member's diagnosis	
For cosmetic procedures:	
<input type="checkbox"/> 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	
Just remember: You can't use this form to initiate a precertification request. To initiate a request, you may submit your request electronically or call our Precertification Department.	
Signature of person completing form:	
Date: / /	
Contact name of office personnel to call with questions:	
Telephone number: 1-	