# Oral 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

This form replaces all other Oral Surgery – Bone Grafts and Implants precertification information request documents and forms. **Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.**

**Once completed, this form contains confidential information.** Only the individual or entity it's addressed to can use it. If you're not the intended recipient, or the employee or agent responsible for delivering the form to the intended recipient, you can't disseminate, distribute or copy the completed form. If you received the completed form in error, call us at **1-800-624-0756** or **1-888-632-3862**.

## How to fill out this form

As the patient's attending physician, you must complete Sections 2 through 6 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:

- 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.

- Send your information by 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.

- Mail your information to: **PO Box 14079**
  **Lexington, KY 40512-4079**
- Email requests that require photographs to*:* Precertification Commercial and Medicare (including expedited): **oralandmaxillofacialsurgery@aetna.com**

## What happens next?

Once we receive the requested documentation, we will perform a clinical review. Then we'll make a coverage determination and let you know our decision.

## 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 is not an available NCD or LCD to review, then the Clinical Policy Bulletin referenced below will be used as a resource in decision making.

For all other members, we encourage you to review **Clinical Policy Bulletin #82: Dental Services and Oral and Maxillofacial Surgery: Coverage Under Medical Plans**, 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.

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| | |
|---|---|
| **Fax to:** Precertification Department | **Fax number: 1-833-596-0339** |
| **Section 1: To be completed by the Precertification Department** | |
| **Member name:** | |
| **Member ID:** | **Member date of birth:** |
| **Physician name:** | **Physician NPI:** |
| **Physician fax number:** 1- | **Physician status:** ☐ Participating ☐ Non-participating |
| Reference #: - - . This is the reference number for oral surgery bone grafts and implants request for the above member. **This is not an approval**. Your request requires clinical review and a decision is pending. We'll contact your office/facility once we make a coverage determination. | |
| **Section 2: Provide the following general information** | |
| **Facility name:** | |
| **Facility fax number:** 1- | **Facility status:** ☐ Participating ☐ 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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| **Fax to:** Precertification Department | **Fax number: 1-833-596-0339** |
| **Member name:** | |
| **Member ID:** | **Reference Number:** |

**Section 3: Provide the following patient-specific information**

**Select the following that apply to this request:**

☐ Bone graft ☐ Dental implant ☐ Other; Please specify:

**Is this request the result of a trauma or accidental injury?**

☐ Yes ☐ No

If yes, please submit the following:

- Pre-trauma/accident and post-trauma/accident x-rays
- Accident report

**Select the indication for the requested service(s):**

☐ Placement of bone grafts into extraction sites. Please specify site(s)
☐ Repair of cleft palate
☐ Stabilization of a maxillofacial prosthesis (e.g., obturator)
☐ Surgical placement of the dental implant body (replacement of the missing root)
☐ Radiolucent lesion (potentially cystic) has expanded to the point that there may be a risk for pathologic fracture
☐ Adjunctive procedure to the surgical placement of the dental implant body
☐ Other; Please specify:

**Section 4: Provide the following documentation for your request**

- Letter of medical necessity/rationale for requested procedure(s)
- Pre-operative panorex CT or MRI
- Pathology report
- Any supporting medical records documenting clinical findings, conservative management with outcome, and current plan of care

**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**

**Signature of person completing form:**

**Date:** / /

**Contact name of office personnel to call with questions:**

**Telephone number:** 1- - -