Orthognathic 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.

GR-69324 (1-21)

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About this form
This form replaces all other Orthognathic Surgery 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 #95: Orthognathic Surgery**, before you complete this form.

You can find the Clinical Policy Bulletin 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 orthognathic surgery 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.)	

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 indication for the requested service(s):

- ☐ Antero-posterior discrepancies
  - ☐ Maxillary/mandibular incisor relationship: overjet of 5 millimeter (mm) or more, or a 0 to a negative value (norm 2 mm)
  - ☐ Maxillary/mandibular antero-posterior molar relationship discrepancy of 4 mm or more (norm 0 to 1 mm).
- ☐ Vertical discrepancies
  - ☐ Presence of a vertical facial skeletal deformity which is 2 or more SDs from published norms for accepted skeletal landmarks
  - ☐ Open Bite (No vertical overlap of anterior teeth greater than 2 mm or Unilateral or bilateral posterior open bite greater than 2 mm)
  - ☐ Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch
  - ☐ Supraeruption of a dento-alveolar segment due to lack of opposing occlusion creating dysfunction not amenable to conventional prosthetics
- ☐ Transverse discrepancies
  - ☐ Presence of a transverse skeletal discrepancy which is 2 or more SDs from published norms
  - ☐ Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth.
- ☐ Asymmetries
  - ☐ Antero-posterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry
- ☐ Facial Skeletal Discrepancies Associated with Documented Sleep Apnea, Airway Defects, and Soft Tissue Discrepancies
- ☐ Speech Impairments accompanying severe cleft deformity
- ☐ Other; Please specify:

Section 4: Provide the following documentation for your request

- Letter of medical necessity/rationale for requested procedure(s)
- Panorex dated X-ray
- Cephalometric X-ray with Analysis
- Tracings
- Facial and Occlusal photos
- Orthodontic History
  - Any supporting medical records documenting clinical findings, conservative management with outcome, and current plan of care

Fax to: Precertification Department	**Fax number: 1-833-596-0339**
Member name:	
Member ID:	**Reference Number:**
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- - -	