Sleep Apnea Appliance
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 Sleep Apnea Appliance 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 #4: Obstructive Sleep Apnea in Adults**, 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 the sleep apnea appliance 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
Date of procedure: / /	
Diagnosis code(s):	
CPT/HCPCS codes, with descriptions, which best describe the service(s) you'll provide.	
Specify the type (name/brand) of oral appliance requested:	
Is this a replacement appliance? ☐ Yes ☐ No **If yes, length of time patient has had the current appliance**	

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

Section 3: Provide the following patient-specific information

Select the indication that applies to this request:

- ☐ Apnea Hypopnea Index (AHI) or respiratory disturbance index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events
- ☐ AHI or RDI is greater than or equal to 5 and less than 15 events per hour with a minimum of 10 events
  - ☐ Documented history of stroke
  - ☐ Documented hypertension (systolic blood pressure greater than 140 mm Hg and/or diastolic blood pressure greater than 90 mm Hg)
  - ☐ Documented ischemic heart disease
  - ☐ Documented symptoms of impaired cognition, mood disorders, or insomnia
  - ☐ Excessive daytime sleepiness (documented by either Epworth greater than 10 or MSLT less than 6)
  - ☐ Greater than 20 episodes of oxygen desaturation (i.e., oxygen saturation of less than 85 %) during a full night sleep study, or any 1 episode of oxygen desaturation (i.e., oxygen saturation of less than 70 %).
- ☐ AHI is greater than 30 or the RDI is greater than 30
  - ☐ The member is not able to tolerate a positive airway pressure (PAP) device; or
  - ☐ The use of a PAP device is contraindicated.
- ☐ Upper airway resistance syndrome (UARS)
- ☐ Snoring
- ☐ Other, please specify

Submit the sleep study report and any pertinent medical records to support the indication for this request

Section 4: Provide the following documentation for your request

- Letter of medical necessity/rationale for requested procedure(s)
- Sleep study report
- Documentation of PAP trial or contraindication to PAP device
- Current history and physical
- Office notes related to the patient's condition for which treatment is proposed

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- - -