Sinus Surgery
Precertification Information Request Form

Applies to:

Aetna plans

Innovation Health® plans

Health benefits and health insurance plans offered and/or underwritten 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 will help you supply the right information with your precertification request. **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:

- 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 www.availity.com or learn more about Availity at www.availity.com/aetnatraining.

- 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

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 #937: Sinus Surgeries** 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**

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Section 1: Provide the following general information	
Member name:	**Reference number (required):**
Member Phone Number: - -	
Member ID:	**Member date of birth:**
Requesting provider/facility/vendor name:	
Requesting provider/facility/vendor NPI:	
Requesting provider/facility/vendor phone number: 1- - -	
Requesting provider/facility/vendor fax number: 1- - -	
Assistant/co-surgeon name (if applicable):	**TIN:**

Section 2: Provide the following patient-specific information.

What diagnosis (es) you are treating (ICD-10)?
What are the requested procedures (CPT codes)?

Describe the indication for the sinus surgery:

Will the surgery be image-guided? ☐ Yes ☐ No
If yes, please provide the indication for image guidance.

How long has the patient had symptoms?
Date symptoms started: / /

Document the medical therapy that has been tried and failed.
Antibiotics: Start date / / End date / /
Intranasal steroids: Start date / / End date / /
Daily saline nasal irrigation: Start date / / End date / /
Other (please describe):

Is this a re-do or revision sinus surgery? ☐ Yes ☐ No
If yes, please provide the following information:
Description of previous sinus surgery: Date of previous sinus surgery: / /
How long has the patient had symptom?
Antibiotics after surgery: Start date / / End date / /
Has the patient had endoscopic or CT imaging since surgery? ☐ Yes ☐ No **If yes, please submit report(s).**

Section 3: Provide the following documentation for your request

- ☐ CT imaging of sinuses
- ☐ Nasal endoscopy report (if done)
- ☐ Current history and physical
- ☐ Description of proposed treatment
- ☐ Laboratory/pathology reports, as applicable
- ☐ Supporting medical records documenting clinical findings, conservative management, outcome and current plan of care.

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Member Name:	Member Phone Number:
Member ID:	Reference number (required):

Section 4: 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 5: Sign the form

Just remember: You can't use this form to initiate a precertification request. To initiate a request, you can 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- - -