

Gender Affirming Surgery Aetna Student Health Precertification Information Request Form

About this form

You can't use this form to initiate a precertification request. To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically. **Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.**

This form replaces all other gender affirming surgery precertification information request documents and forms. This form will help you supply the right information with your precertification request. You don't have to use the form. But it will help us adjudicate your request more quickly.

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. This includes Innovation Health Plan, Inc. and Innovation Health Insurance Company.

When you're done

Once you've filled out the form, submit it and all requested medical documentation to our Precertification Department by:

- **(Preferred)** Upload your information electronically on our secure provider website at www.Availity.com.
- 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. Thank you.
- 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 #615: Gender Affirming Surgery**, 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 any 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**

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).



Section 1: Provide the following general information
If submitting request electronically, complete member name, ID and reference number only

Member name: Reference number (required):
Member ID: Member date of birth: / /
Requesting provider/facility name:
Requesting provider/facility NPI:
Requesting provider/facility phone number: 1- - - Fax number: 1- - -
Assistant/co-surgeon name (if applicable): TIN:
Referral on file, if applicable, with Student Health Center and Aetna Student Health? Yes No N/A

Section 2: Provide the following patient-specific information.

Is this a new or continued treatment? New Continued
Does the patient have persistent, well-documented gender dysphoria? Yes No
Does the patient have the capacity to make a fully informed decision and to consent for treatment? Yes No
Does the patient currently have significant medical concerns? Yes No
If yes, are they reasonably well controlled? Yes No
Does the patient currently have significant mental health concerns? Yes No
If yes, are they reasonably well controlled? Yes No
Does the patient have substance abuse and/or chemical dependency concerns? Yes No
Is the request for female-to-male/non-binary services? Yes No If yes, go to Section 3.
Is the request for male-to-female/non-binary services? Yes No If yes, go to Section 4.

Section 3: Complete this section if request is for female-to-male/non-binary services
Select the requested service(s)

Mastectomy
Breast removal (transgender mastectomy) use Reduction Mammoplasty code as mastectomy code is no longer applicable for transgender female-to-male/non-binary breast surgery.
Does the patient have one referral letter from a qualified mental health professional? Yes No
For members below the age of 18: Has the member completed one year of testosterone treatment? Yes No
If yes, please provide the date range of testosterone treatment: / / to / /
Gonadectomy (hysterectomy and oophorectomy) or Genital reconstructive surgery (vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, placement of a testicular prosthesis and erectile prosthesis)
Does the patient have two referral letters from qualified mental health professionals, one in a purely evaluative role? Yes No
Does the patient have 12 months of continuous hormone therapy appropriate for their gender goals? Yes No
If yes, please provide the start date: / /
If no, does the patient have a contraindication or is otherwise unable or unwilling to take hormones? Yes No Please describe:
Genital reconstructive surgery only: Has the patient been living in a gender role that is congruent with their gender identity (real-life experience) for 12 months? Yes No
If yes, please provide the start date: / /



Precertification Information Request Form

Section 4: Complete this section if request is for male-to-female/non-binary services

Select the requested service(s)

Member Name:

Member ID:

Reference Number:

- Orchiectomy or** **Genital reconstructive surgery** (penectomy, vaginoplasty, labiaplasty and clitoroplasty)
Does the patient have two referral letters from qualified mental health professionals, one in a purely evaluative role?
 Yes No
Does the patient have 12 months of continuous hormone therapy appropriate for their gender goals?
 Yes No
If yes, please provide the start date: / /
If no, does the patient have a contraindication or is otherwise unable or unwilling to take hormones?
 Yes No

- Genital reconstructive surgery only:** Has the patient been living in a gender role that is congruent with their gender identity (real-life experience) for 12 months? Yes No
If yes, please provide the start date: / /

- Breast Augmentation**
Breast augmentation (implants/lipofilling) for male-to-female members:
Does the member have a single letter of referral from a qualified mental health professional? Yes No
Persistent, well documented gender dysmorphia? Yes No
Capacity to make a fully informed decision and consent to treatment? Yes No
Age of Majority? (18 or older) Yes No
Has the member completed One (1) year of feminizing hormone therapy prior to breast augmentation? Yes No
Does member have significant medical or mental health concerns? Yes No

Section 5: Provide the following documentation for your request

- Current history and physical
- Office notes related to the patient's condition
- Description of proposed treatment
- Mental health referral letter(s)
- Documentation of mental health conditions, if applicable
- Documentation of substance abuse/chemical dependency issues, if applicable
- Documentation of hormone therapy, including duration, if applicable

Section 6: 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 7: Sign the form

Just remember: You can't use this form to initiate a precertification request. To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically.

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -