Gender Affirming 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

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

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.
- 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**

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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: - -	
Requesting provider/facility fax number: 1- - -	
Assistant/co-surgeon name (if applicable):	**TIN:**

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)

☐ Breast removal (transgender mastectomy)
Use Reduction Mammaplasty code as mastectomy code is not applicable to transgender female-to-male/non-binary breast surgery.
Does the patient have a single letter of referral from a qualified mental health professional? ☐ Yes ☐ No
Does the patient have persistent, well documented gender dysmorphia? ☐ Yes ☐ No
Does the patient have the capacity to make a fully informed decision and consent to treatment? ☐ Yes ☐ No
Is the patient at the age of Majority? (18 or older) ☐ Yes ☐ No
If no, what is date range of testosterone treatment? / / to / /
Does patient have significant medical or mental health concerns? ☐ Yes ☐ No

☐ **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: / /

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

Section 4: Complete this section if request is for *male-to-female* /non-binary services
Select the requested service(s)

☐ **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
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: / /

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

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