Wheelchairs and Power Operated Vehicles (Scooters) 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, please call our Precertification Department or you may 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.**

Effective **April 1, 2020**, this form replaces all other Wheelchairs and Power Operated Vehicles (Scooters) 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 clinical information electronically on our secure provider portal at www.Availity.com.
- Send your clinical information via 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. 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 #271: Wheelchairs and Power Operated Vehicles (Scooters),** 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**

Wheelchairs and Power Operated Vehicles (Scooters)
Precertification Information Request Form

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

Section 2: Provide the following patient-specific information

Does the patient have a mobility limitation that significantly impairs the ability to participate in one or more mobility-related activities of daily living (MRADLs) (e.g., toileting, feeding, dressing, grooming, bathing) in customary locations in the home that would be alleviated by the requested mobility device? ☐ Yes ☐ No

Is the patient ambulatory? ☐ Yes ☐ No

If yes, how many feet can the patient ambulate with and without an assistive device (e.g., cane or walker)?

Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker?
☐ Yes ☐ No

Is it anticipated the patient's condition will not resolve within 3 months? ☐ Yes ☐ No

Is the patient able to self-propel a manual wheelchair? ☐ Yes ☐ No

If no, please document why the patient is unable to self-propel.

Has the patient shown the ability to safely operate the requested mobility device? ☐ Yes ☐ No

Does the patient's home provide adequate access between rooms, maneuvering space and surfaces for the operation of the requested device? ☐ Yes ☐ No

Is the requested device for use primarily outside the patient's home? ☐ Yes ☐ No

Does the patient currently own a wheelchair? ☐ Yes ☐ No

If yes, provide the following information about the current wheelchair:

☐ Manual ☐ Power operated

Specify the features on the power wheelchair

☐ Tilt ☐ Recline ☐ Power legs ☐ Seat Elevator

☐ Other, please specify

Specify the age of the current wheelchair

Detailed list of repairs, including cost, needed for the current wheelchair:

Explain why the current device is not adequate to meet the patient's needs:

Wheelchairs and Power Operated Vehicles (Scooters)
Precertification Information Request Form

Member ID:	**Reference Number:**

Section 2 Continued: Provide the following patient-specific information

☐ Adjustable arm-height option	☐ Enhanced joystick	☐ Mechanical linked leg elevation feature	☐ Power tilt and/or recline seating systems	☐ Side guard
☐ Anti-rollback device and anti-tip device	☐ Gear reduction drive wheel	☐ Non-powered or powered seat elevator or standing device	☐ Power wheelchair drive control systems	☐ Solid seat insert or other custom seating option(s)
☐ Arm trough	☐ Headrest	☐ Non-standard seat width, depth, or height	☐ Push-rim activated power assist device	☐ Swingaway retractable, or removable hardware
☐ Batteries: U-1 battery, 22 NF deep-cycle lead acid battery, gel battery or Group 24 battery	☐ Lap tray wheelchair attachment	☐ One-arm drive attachment	☐ Reinforced back upholstery or reinforced seat upholstery	☐ Tilt-in-space
☐ Chin control	☐ Lever activated wheel drive	☐ Power add-ons to manual wheelchairs	☐ Safety belt/pelvic strap	☐ Rotation-in-space
☐ Electronic interface control lights or other electrical devices	☐ Manual fully reclining back option	☐ Power leg elevation feature	☐ Semi-reclining back option	
☐ Elevating leg rests	☐ Mechanical or power shear reduction features	☐ Power stander attachment	☐ Shoe holder	

Section 3: Provide the following documentation for your request

- Itemized invoice for the requested mobility device and all accessories
- Current history and physical
- Current evaluation from the durable medical equipment (DME) vendor for the requested mobility device

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, please call our Precertification Department or submit your request electronically.

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:

Telephone number: 1- - -