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)



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). Aetna provides certain management services on behalf of its affiliates.

Proton Beam Radiotherapy Precertification Information Request Form

About this form

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

This form replaces all other Proton Beam Radiotherapy 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:

- 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 via confidential fax to: Precertification Commercial and Medicare 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 #270: Proton Beam and Neutron Beam Radiotherapy 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
 Medicare plans: 1-800-624-0756

Proton Beam Radiotherapy Precertification Information Request Form

Section 1A: Provide the following general information for all requests					
Member name:					
Member phone number:					
Member ID:		Reference number (required):			
Section 1B: Provide the following general information - If submitting request electronically, skip this section.					
Member date of birth:					
Requesting provider/facility name:					
Requesting provider/facility NPI:					
Requesting provider/facility phone number: 1					
Requesting provider/facility fax number: 1					
Section 1C: Provide the Radiation Oncologist information if not the ordering provider					
Rad	diation Oncologist name:	TIN:			
		PIN or NPI:			
Address:		City:	State: ZIP:		
Phone number:		Fax number:			
Section 2: Provide the following patient-specific information.					
1.	Describe the diagnosis that applies to your patient: Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases Head and neck cancers (excluding T1-T2N0M0 laryngeal cancer) that cannot be completely resected Ocular tumors, including intraocular/uveal melanoma (includes the iris, ciliary body and choroid) Paranasal sinus or nasopharyngeal tumors Primary CNS cancer that cannot be completely resected Primary or metastatic tumors of the spine where the spinal cord tolerance would be exceeded with photon radiotherapy approaches Radiosensitive malignancy in children (21 years of age and younger) Skull-based tumors, (e.g.,_chordomas or chondrosarcomas Uveal melanomas confined to the globe (i.e., not distant metastases) Other, please specify				
2.	a. Does the patient have any distant metastatic disease bone)?	(stage M1) (i.e. to brain, lung, liver	☐ Yes ☐ No		
-	b. If yes, is treatment being directed to the primary or me	etastatic lesion?	Primary lesion Metastatic lesion		

Continued

Proton Beam Radiotherapy Precertification Information Request Form

Member name:		Reference number (required):			
Section 2: Provide the following patient-specific information (continued).					
3.	Is planned treatment curative?		☐ Yes ☐ No		
4.	Is the area to be treated abutting or overlapping a previous	ly irradiated area?	☐ Yes ☐ No		
5.	a. Is the patient being treated on a clinical trial?		☐ Yes ☐ No		
	b. If yes, what is the NCT trial number?				
6.	What is the total planned dose?				
	What is the number of proton beam radiotherapy fractions?				
Section 3: Provide the following documentation for your request					
 Radiation oncologist consultation note(s) Current history and physical Medical records related to the patient's condition for the proposed treatment, including the following: Detailed radiation treatment plan Documentation of all clinical findings Type, duration and outcome of any prior surgical or radiotherapy treatment All radiology and imaging reports documenting the presence or absence of metastatic disease 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 may submit your request electronically or call our Precertification Department.					
Fo	rm completed by:	Title:			
Signature of person completing form:					
Date: / /					
Contact name of office personnel to call with questions: Telephone number: 1					
Contact name of radiation oncologist personnel to call with questions: Telephone number: 1					
Contact name of radiation facility personnel to call with questions: Telephone number: 1					

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