Skilled Home Private Duty Nursing Care 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)

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.

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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 medical records we are requesting may result in the delay of review or denial of coverage.**

This form replaces all other Skilled Home Private Duty Nursing Care 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:

- 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 (**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 # 136: Skilled Home Private Duty Nursing Care**, 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 **1-800-424-4047**.

Skilled Home Private Duty Nursing Care
Precertification Information Request Form

Section 1: Provide the following general information
If submitting request electronically, complete member name, ID and reference number only
For Medicare members, all home care is provided through a CMS approved provider/agency. We encourage the use of a participating provider for optimizing quality of care and clinical outcomes

Member name:	**Reference number (required)**
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- - -

Section 2: Provide the following patient-specific information

Is this an initial request or an extension request? ☐ Initial ☐ Extension
If initial request, what is the projected hospital discharge date?
Start date of skilled home private duty nursing care: / /

Hours per day patient needs private duty nursing:
Number of visits requested:
Check all that apply to the patient:
- ☐ Patient is being transitioned from an inpatient setting to home
- ☐ The additional skilled nursing care will prevent a hospital admission
- ☐ Patient meets the clinical criteria for confinement in a skilled nursing facility (SNF), but a SNF bed is not available

Describe the prognosis and estimated length of time PDN services will be needed:

Describe the specific nursing interventions needed in detail:

Describe the patient's current living situation

Is there a caregiver in the patient's home? ☐ Yes ☐ No
If yes, what is the caregiver's relationship to the patient?
Is there a written care plan in place that includes training for the caregiver?

Is the patient confined to the house? ☐ Yes ☐ No

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Member name:	**Reference number (required)**

Section 3: Complete this section for patients on ventilators

Date the patient became ventilator dependent: / /
Hours per day the patient is ventilator dependent:

Section 4: Provide the following documentation for your request

Please check all as obtained:

- ☐ Letter of medical necessity Signed and dated by the ordering physician (CMS form 485 signed and dated for Medicare Advantage members)
- ☐ Diagnosis
- ☐ History and physical
- ☐ Physician orders, including duration of services and treatment plan signed by physician
- ☐ **Extension requests:** nursing /clinical assessment summary notes and at least 1-2 weeks of shift notes

Section 5: 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 6: Sign the form

Just remember: 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.

Signature of person completing form:

Date: / /

Contact name of office personnel to call with questions:
Telephone number: 1- - -