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

Do not use this form to initiate a precertification request. To initiate a request, submit electronically on Availity or call our Precertification Department. Submit your medical records to support the request with your electronic submission.

We've made it easy for you to authorize services and submit any requested clinical information. Just use our provider portal on Availity®. Register today at **Availity.com/aetnaproviders**. Once your account is ready, you can start submitting authorization requests right away.

- For additional information on Availity, go to **https://www.aetna.com/health-care-professionals/resource-center/availity.html**

Requesting authorizations on Availity is a simple two-step process

Here's how it works:

1. Submit your initial request on Availity with the Authorization (Precertification) Add transaction.
2. Then complete a short questionnaire, if asked, to give us more clinical information.
   - If you receive a pended response, then complete this form and attach it to the case electronically.

This form will help you supply the right information with your precertification request. Typed responses are preferred. Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.

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:

- If your request was submitted via telephone, you can either:
  - Access our provider portal via Availity; enter the Reference number provided and attach this form and all requested medical documentation to the case or
  - Send your information by 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.
  - If you do not have fax or electronic means to submit clinical:
    - Mail your information to: **PO Box 14079**
      Lexington, KY 40512-4079
      (Please note mailing will add to the review response time)

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 questions about how to fill out the form or our precertification process, call us at:

- HMO plans: **1-800-624-0756** **(TTY: 711)**
- Traditional plans: **1-888-632-3862** **(TTY: 711)**
- Medicare plans: **1-800-624-0756** **(TTY: 711)**

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Precertification Information Request Form

Section 1: Provide the following general information Typed responses are preferred. If the responses cannot be typed, they should be printed clearly. If submitting request electronically, complete member name, ID and reference number only	
Member name:	**Reference number (required):**
Member ID:	**Member date of birth:**
Member phone number:	
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:

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Precertification Information Request Form

Member ID:	**Reference Number:**

Section 2 Continued: Provide the following patient-specific information

☐ Adjustable arm-height option	☐ Crutch/Cane holder	☐ Manual fully reclining back option	☐ Power tilt and/or recline seating systems	☐ Semi-reclining back option
☐ Anti-rollback device and anti-tip device	☐ Elevating leg rests	☐ One-arm drive attachment	☐ Power wheelchair drive control systems	☐ Shoe holder
☐ Arm trough	☐ Flat free insert	☐ Power add-ons to manual wheelchairs	☐ Push handles	☐ Side guard
☐ Batteries: U-1 battery, 22 NF deep-cycle lead acid battery, gel battery or Group 24 battery	☐ Headrest	☐ Power leg elevation feature	☐ Push-rim activated power assist device	☐ Solid seat insert or other custom seating option(s)
☐ Chin control	☐ Lap tray wheelchair attachment	☐ Power seat elevator	☐ Safety belt/pelvic strap	☐ Swing away retractable, or removable hardware
				☐ Tilt-in-space

Section 3: Provide the following documentation for your request

- Standard Written Oder – listing each item HCPCS code and description
- Face to Face chart note from the prescribing physician
- Specialty evaluation, when required
- Itemized quote for the requested mobility device and all accessories
- Proof of Assistive Technology Professional involvement and home evaluation

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- - -