

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)



Orthognathic Surgery Precertification Information Request Form

About this form

This form replaces all other Orthognathic Surgery precertification information request documents and forms.

Failure to complete this form and submit all medical records we are requesting may result in the delay of review or denial of coverage.

Once completed, this form contains confidential information. Only the individual or entity it's addressed to can use it. If you're not the intended recipient, or the employee or agent responsible for delivering the form to the intended recipient, you can't disseminate, distribute or copy the completed form. If you received the completed form in error, call us at **1-800-624-0756** or **1-888-632-3862**.

How to fill out this form

As the patient's attending physician, you must complete Sections 2 through 6 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:

- Use our provider portal on Availity® to also upload clinical documentation, photographs, X-rays, check statuses, and make changes to existing requests. Register today at availity.com/aetnaproviders.
- 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.
- Mail your information to: **PO Box 14079**
Lexington, KY 40512-4079
(Please note mailing will add to the review response time)
- You can email required photographs to: Precertification Commercial and Medicare:
oralandmaxillofacialsurgery@aetna.com

What happens next?

Once we receive the requested documentation, we will perform a clinical review. Then we'll make a coverage determination and let you know our decision.

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 is not an available NCD or LCD to review, then the Clinical Policy Bulletin referenced below will be used as a resource in decision making.

For all other members, we encourage you to review **Clinical Policy Bulletin #95: Orthognathic Surgery**, before you complete this form.

You can find the Clinical Policy Bulletin and Precertification Lists by visiting the website on the back of the member's ID card.

Orthognathic Surgery Precertification Information Request Form

Fax to: Precertification Department	Fax number: 1-833-596-0339
Section 1: To be completed by the Precertification Department 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:	Member phone number:
Member ID:	Member date of birth:
Physician name:	Physician NPI:
Physician fax number: 1-	Physician status: <input type="checkbox"/> Participating <input type="checkbox"/> Non-participating
Reference #: - - . This is the reference number for orthognathic surgery request for the above member. This is not an approval. Your request requires clinical review and a decision is pending. We'll contact your office/facility once we make a coverage determination	
Section 2: Provide the following general information	
Facility name:	
Facility fax number: 1-	Facility status: <input type="checkbox"/> Participating <input type="checkbox"/> Non-participating
Assistant/Co-surgeon name and TIN (if applicable):	
Date of procedure: / /	
Diagnosis code(s):	
CPT/HCPCS codes, with descriptions, which best describe the service(s) you'll provide. (For drugs/injectables, include any administration codes.)	

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Member name:

Member ID:	Reference Number:
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Section 3: Provide the following patient-specific information

Select the indication for the requested service(s):

Antero-posterior discrepancies

- Maxillary/mandibular incisor relationship: overjet of 5 millimeter (mm) or more, or a 0 to a negative value (norm 2 mm)
- Maxillary/mandibular antero-posterior molar relationship discrepancy of 4 mm or more (norm 0 to 1 mm).

Vertical discrepancies

- Presence of a vertical facial skeletal deformity which is 2 or more SDs from published norms for accepted skeletal landmarks
- Open Bite (No vertical overlap of anterior teeth greater than 2 mm or Unilateral or bilateral posterior open bite greater than 2 mm)
- Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch
- Supraeruption of a dento-alveolar segment due to lack of opposing occlusion creating dysfunction not amenable to conventional prosthetics

Transverse discrepancies

- Presence of a transverse skeletal discrepancy which is 2 or more SDs from published norms
- Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater, or a unilateral discrepancy of 3 mm or greater, given normal axial inclination of the posterior teeth.

Asymmetries

- Antero-posterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry

Facial Skeletal Discrepancies Associated with Documented Sleep Apnea, Airway Defects, and Soft Tissue Discrepancies

Speech Impairments accompanying severe cleft deformity

Other; Please specify:

Section 4: Provide the following documentation for your request

- Letter of medical necessity/rationale for requested procedure(s)
- Panorex dated X-ray
- Cephalometric X-ray with Analysis
- Tracings
- Facial and Occlusal photos
- Orthodontic History
 - Any supporting medical records documenting clinical findings, conservative management with outcome, and current plan of care

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Member name:	
Member ID:	Reference Number:
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	
Signature of person completing form:	
Date: / /	
Contact name of office personnel to call with questions:	
Telephone number: 1- - -	