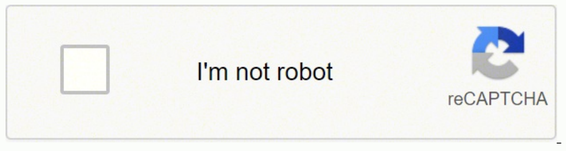

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Aetna provider par form

aetna®

AETNA MANAGED DENTAL SPECIALTY REFERRAL FORM FOR DMO

☐ DIRECT REFERRAL (Eligible only to participating Specialty Dentists) ☐ SPECIALTY APPROVAL

IF SUBMITTING A UNIVERSAL CLAIM FORM FOR PAYMENT OR SPECIALTY APPROVAL, THIS REFERRAL FORM MUST BE INCLUDED.

COMPLETE MEMBER/PATIENT INFORMATION

PART I **EMPLOYEE INFORMATION**

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) PLEASE PRINT | MEMBER IDENTIFICATION NUMBER | GROUP NUMBER OR DISTRICT NUMBER | DATE OF BIRTH (MM/DD/YYYY)

HOME ADDRESS | WORK PHONE | HOME PHONE

CITY | STATE | ZIP CODE | OTHER INSURANCE COVERAGE? ☐ YES ☐ NO | IF YES, NAME OF PLAN

Is this member listed as a Late Entrant (LE) on your Monthly Roster? ☐ YES ☐ NO

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT PAYMENT WILL BE MADE DIRECTLY TO ATTENDING DENTIST.

PATIENT SIGNATURE (If minor, parent signature required) _____ DATE _____

PART II **COMPLETE ONLY IF CLAIM IS FOR A DEPENDENT**

PATIENT'S NAME (LAST, FIRST, MI) if a Dependent | ☐ MALE ☐ FEMALE | DATE OF BIRTH (MM/DD/YYYY) | DEPENDENT STATUS ☐ SPOUSE ☐ CHILD ☐ OTHER | IF CHILD, IS HE/SHE WHOLLY DEPENDENT FOR SUPPORT & MAINTENANCE ☐ YES ☐ NO

REFERRING DENTIST

PART III

REFERRING DR. _____ PHONE # _____ OFFICE CODE # _____

REFERRING TO DR. _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

☐ IN Network ☐ OUT of Network; if so, indicate reason _____

DMO Plan Code _____

ALL PROCEDURES BELOW, PRECEDED BY AN " * ", MUST BE APPROVED PRIOR TO REFERRAL.

PLEASE INDICATE PRIMARY REASON FOR PATIENT REFERRAL:

***ENDODONTICS* - Include Pre-OP and Post-OP Periapical X-rays**

- ☐ Consultation or problem focused examination (please explain below)
- ☐ Molar root canal therapy Tooth # _____
- ☐ Calcified/inaccessible canals (with conclusive radiograph evidence) Tooth # _____
- ☐ Root canal retreatments Tooth # _____
- ☐ Other procedure(s) eligible for direct referral (see list on opposite side of form) _____
- ☐ Other * - **Any other service requires approval. Please explain below.**

***PEDIATRICS* - Direct referral eligible only for consultation/evaluation for children under age 6. Detailed narrative required for children age 6 or over.**

- ☐ Medically compromised or developmentally disabled (please include a physician's statement of condition)
- ☐ Presents a documented behavioral management problem (please indicate below any attempts made to manage patient)
- ☐ Has rampant caries, or
- ☐ Requires emergency care that is beyond the scope or ability of the Primary Care Dentist
- ☐ Other * - **Any other service requires approval. Please explain below.**

***ORAL SURGERY* - Include Pre-OP X-ray/Panoramic X-ray** *(Bitewings are NOT acceptable) and provide rationale for each tooth requested.*

- ☐ Consultation or problem focused examination (please explain below)
- ☐ Single symptomatic and/or pathologically involved partial or full bony impaction Tooth #_____ Symptoms: _____
- ☐ Five or more routine extractions to be performed in one visit (except for 3rd molars) Teeth #s _____ Symptoms: _____
- ☐ Alveoloplasty (in conjunction with three or more extractions in the same quadrant or in an edentulous area)
- ☐ Surgical removal of residual roots
- ☐ Other procedure(s) eligible for direct referral (see list on opposite side of form) _____
- ☐ Other * - **Any other service requires approval. Please explain below.**

***PERIODONTICS* - Include Periodontal charting, full mouth mounted Intraoral X-rays (Panoramic X-ray is NOT acceptable)**

- ☐ Generalized moderate to severe periodontitis - consultation only
- ☐ Indicate date(s) and quadrants Scaling and Root Planing completed _____
- ☐ Other * - **Any other service requires approval. Please explain below.**

ORTHODONTICS - Verify patient is eligible for Orthodontic benefits

- ☐ Consultation or problem focused examination only

Clinical Indications / Rationale / Additional Comments: _____

SIGNATURE OF REFERRING DR. _____ DATE _____

ATTENDING SPECIALIST

PART IV **EXAMINATION, TREATMENT PLAN, and/or SERVICES RENDERED**

Tooth # or Letter	Surface	Description of Services	Date Service Performed MM DD YYYY	Procedure Number (ADA Code)	Fee	Copay Collected

I hereby certify that the procedure(s) indicated by date have been completed and that the copay represents the actual copay collected.

Treating Dentist's Signature _____ TIN/SSN _____ NPI _____

23.09.804.1 H 9-14 R-POD

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Attending Physician Statement

Aetna Life Insurance Company
PO Box 14560
Lexington, KY 40512-4560
ACS Fax#: 866-667-1987

1. Patient Information

Patient Name		Year of Birth
Claim Number	Employer Name	Job Title

Please complete all of the fields below and fax this form back to 866-667-1987 within 2 business days from receipt of this request. If you have any questions or would like to provide this information over the telephone, please call 866-326-1380. Please note, if this information is not received, your patient's request for disability benefits may be denied.

2. Dates of Disability

Disabled from work — Starting ___/___/___ Through ___/___/___

Is the condition work related? ☐ Yes ☐ No If Yes, Date of Injury / Illness ___/___/___

Expected Return to Work Date ___/___/___ ☐ Modified Duty ☐ Full Duty

3. Restrictions and Limitations (please indicated below): The patient's employer may be able to accommodate temporary or modified duty assignments within the limitations/restrictions you provide below:

(O)ccasional = .5 – 2.5 hrs **(F)**requent = 2.6 – 5.0 hrs **(C)**ontinuous = 5.1 – 8.0 hrs

Sitting _____	Lifting _____	(# of pounds) _____	Keying / Computer _____
Standing _____	Pushing / Pulling _____		Hand grasping _____
Walking _____	Bending / Stooping _____		Repetitive motion _____
Driving _____	Other _____		Reaching _____

4. Diagnosis / Symptoms (Please list primary, secondary and other medical conditions)

ICD-9 Description and Code(s): 1. _____ 2. _____ 3. _____

Symptoms: _____

5. Surgery and Treatment

Hospitalized	If Hospitalized	Surgery Date
☐ Yes ☐ No	Admitted on ___/___/___ Discharged on ___/___/___	___/___/___

CPT Description and Code(s): 1. _____ 2. _____ 3. _____

6. Treatment Summary (including referrals for testing, physical therapy or another physician)

Medication(s) including Dosage, Frequency and Duration

Most Recent Office Visit Date	Date of Next Office Visit	Treatment Frequency
___/___/___	___/___/___	

Has patient been referred to another physician? ☐ Yes ☐ No

If Yes: Physician Name: _____ Specialty: _____

Phone Number: _____ Fax Number: _____

7. Signature

Physician's Signature		Date (MM/DD/YYYY) ___/___/___
Physician Name	Specialty	
Phone Number	Fax Number	
Address		

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. ***Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.***

WKAB STD Only

GC-1638-26 (9-12)

Claim Form

Aetna Global Benefits®

☐ Medical* ☐ Dental* ☐ Vision*

** Refer to your plan documents to verify the coverage(s) that are available through your Plan.*

Please also complete Page 2 of this form.

Please mail or fax completed Claim Form with itemized bills and receipts. A separate claim form is needed for each family member. Please tape small receipts on 8.5 x 11 paper.

Aetna Global Benefits
P.O. Box 30258
Tampa, FL 33630-3258
USA

OR

Aetna Global Benefits
4630 Woodlands Corporate Blvd.
Tampa, FL 33614
USA

Telephone: (800) 231-7729 (outside the USA, via AT&T + access)
(813) 775-0190 (direct or collect outside the USA)
Facsimile: (800) 475-8751 (outside the USA, via AT&T + access)
(813) 775-0625 (inside the USA)
E-mail: agbservice@aetna.com

1. Employee Information

Employer Name/Group Number _____

Employee's Name _____
(First Name, Middle Initial, Last Name/Surname as displayed on Aetna ID Card)

Identification Number *(Use the number specified on your AETNA ID card)* ☐☐☐☐☐☐☐☐☐

Employee's Birthdate *(mm/dd/yyyy)* ☐☐/☐☐/☐☐☐☐ Gender ☐ Male ☐ Female

City _____

State/Province _____ Country _____

Employee's Telephone Number *(Include Country Code)* _____

Employee's Primary E-Mail Address _____
(Email addresses are strongly encouraged in the event additional information is needed to process your claim.)

2. Patient Information

Patient's Name *(First Name, Middle Initial, Last Name/Surname)* _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient's Birthdate *(mm/dd/yyyy)* ☐☐/☐☐/☐☐☐☐ Gender ☐ Male ☐ Female

If the patient is over the age of 19 and attending school, you must provide verification, such as report cards, tuition statements, etc., once per school year.

3. Summary of Medical, Dental, and Vision Services (Please include diagnosis or reason for treatment for each service received.)

- **For Prosthetic services** (crowns, bridges or dentures) the following information must be supplied:
  - The x-rays. (If x-rays are not available, provide the dentist's narrative report.)
  - For dentures and bridges: the date or dates of extraction of teeth involved. If it is a denture or bridge replacement, include the date of prior placement **and reason for replacement**.
  - If the claim is for a bridge or denture, we will need a chart of all other missing teeth in the mouth, and their dates of extraction.
- **For periodontal services** (gum disease), member must submit x-rays and periodontal charting.
- **For orthodontic services, the following information must be provided: date appliance placed, number of months of treatment, months of treatment remaining.**
- **For services related to an accidental injury**, the patient must always include pre-treatment x-rays and details of the accident.

Dates of Service (mm/dd/yyyy)	Provider's (physician, clinic, hospital) Name and Address (If the Provider's name and address is on receipts, write "see receipts")	Description of Service (If hospital, indicate inpatient or outpatient)	Diagnosis (Reason for visit)	City/State/ Province/Country of Claim	Currency of Claim	Total Charge

4. Claim Information

If Yes is answered to either question below, c and d in this section must be completed.

a. Is the claim related to a work related accident or condition? ☐ Yes ☐ No

b. Is the claim related to an accidental injury? ☐ Yes ☐ No

c. Accident Date *(mm/dd/yyyy)* ☐☐/☐☐/☐☐☐☐ Time _____ ☐ AM ☐ PM

d. Description of Accident *(How and Where)*

_____

_____

_____

Please Retain A Copy For Your Records

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

aetna®

Prior Authorization Form

Fax to: **1-866-366-7008** Telephone: **1-844-835-4930**

A determination will be communicated to the requesting provider.

- Incomplete requests will delay the prior authorization process.
- Please include pertinent chart notes to expedite this request.

TYPE OF REQUEST

URGENT (When a 7 calendar day non-urgent prior authorization could seriously jeopardize; the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or that a delay in treatment would subject the member to sever pain that could not be adequately managed without the are/service requested.)

NON-URGENT (for routine services – response within 7 calendar days)

INPATIENT

OUTPATIENT

HOME HEALTH CARE

PATIENT INFORMATION

Patient Name: Last First MI			**Date of Birth:** / /
I.D.#:		**Gender:** M F	**EPSDT special service request?**
Other Insurance? YES NO	**Name of Carrier**	**Job Related?** YES NO	**MVA?** YES NO	**Is the member currently pregnant** YES NO

FROM- REQUESTING PROVIDER

Requesting Provider (Please Print):			**Tax ID#:**
Contact Person in Requesting Provider's Office:	**Telephone:** ( ) -	**Fax:** ( ) -	**WV Medicaid Provider #:**
Clinical Contact Person: **Phone:** ( ) -		**Name of PCP:**	

TO- WHERE WILL PATIENT RECEIVE SERVICES?

Physician/Provider/Facility Requested:	**Address:**	**Telephone:** ( ) -	**Fax:** ( ) -
Where services will be rendered? (Provide name of facility, if other than provider office or patient's home)			**WV Medicaid Provider #:**
Today's Date: / /		**Tentative Date of Service/Admission:** / /	
Were member school based services interrupted? YES NO		**Start Date:** / / **End Date:** / /	

CLINICAL INFORMATION

ICD- 10 Codes: (required) 1 2 3 4	**ICD- 10 Description:**
CPT/HCPCS CODES: (required) 1 2 3 4	**CPT/HCPCS Description:**
Comments (list # Days/Visits/Units or if services are needed at discharge): ***DME, Therapies and Infusions must have Rx attached.***	

CLINICAL INDICATIONS/RATIONALE FOR REQUEST:

To expedite a determination on your request for services, please attach clinical documentation/medical records to support your request. Please include the following: Conservative treatment tried and failed, applicable diagnostic testing with results and lab values and a medication list.

www.aetnabetterhealth.com/westvirginia

WV-16-06-01

aetna

AETNA BETTER HEALTH ®
Prior Authorization Form
REQUEST FOR MEDICAL EQUIPMENT/MEDICAL SUPPLIES

Phone: 1-855-232-3596
Fax: 1-844-797-7601
Date of Request:_____

MEMBER INFORMATION

Name _____ID Number_____
Date of Birth_____ Gender (circle one) F M
Member Address (Confirmed): _____
Delivery
Address: _____

REQUESTING PHYSICIAN OR PROVIDER INFORMATION

Referring Provider/ Requesting Provider
Name _____
Address_____
Telephone #_____ Fax #_____
Specialty_____National Provider ID (NPI)_____

AUTHORIZATION INFORMATION

Requested Equipment/ Medical Supplies (CPT Code(s) or HCPCS_____
Diagnosis Related to Need (ICD-Code(s))_____
Member WT:_____ Member HT:_____
Length of Need_____

****Medical Necessity as determined by physician: (Please describe in space below)****

****Please provide any additional documentation which may be related to the request which supports medical necessity****
Physician Signature_____
UPIN#_____
Date_____

This form shall be considered a physician script, unless a standard script is necessary for the vendor

Case Manager Name/ Phone Number_____ **Fax Number**_____

Level 2 appealIf practitioners are not satisfied with the Level 1 appeal decision, they may request a Level 2 appeal, either verbally or in writing, within 60 calendar days from the date of the Level 1 appeal decision. If the Level 2 appeal decision is in your favor, we will recalculate and reprocess the claim for any services affected by the decision. Examples include, but are not limited to: Provider contract issues Claim payment policies Processing error Level 1 appeal: An oral or written request by a practitioner/provider to change: An adverse reconsideration decision An adverse initial claim decision based on medical necessity or experimental/investigational coverage criteria An initial precertification/patient management review decision Practitioners and organizational providers may request Level 1 appeals. If we need additional information, we will send the Level 1 appeal decision within 30 business days of receipt of the additional requested information. The member appeal process applies to appeals related to pre-service or concurrent medical necessity decisions.Level 2 appeal: An oral or written request by a practitioner to change a Level 1 appeal decision. If the decision is in your favor, we will recalculate and reprocess the claim for any services affected by the decision.Following reconsideration, if the decision is not in your favor, you may initiate a Level 1 appeal. For these types of issues, the practitioner/organizational provider appeal process only applies to appeals received subsequent to the services being rendered. Utilization review disputes are handled as Level 1 appeals and reviewed by clinicians as well.Reconsideration If you would like to dispute a claim payment decision, contact us to have the decision reconsidered. Treating providers are solely responsible for medical advice and treatment of members. Behavioral health organizations include, but are not limited to mental health and chemical dependency hospitals, residential treatment facilities, partial hospital programs, intensive outpatient programs and clinics. If we need additional information, we will send the Level 2 appeal decision within 30 business days of receipt of the additional requested information. After the first level of appeal, the internal Aetna appeal process for organizational providers is exhausted.Claims issues:Issues relate to all decisions made during the claims adjudication process, including those that result in an overpayment, (for example, related to the provider contract, our claims payment policies, processing error, etc.). If the Level 2 appeal decision upholds our original position, we will send a final resolution letter. We will issue a response within 30 business days if no additional information is required, or within 30 business days of when the specialty unit receives any additional requested information. We will provide instructions on how and when to file an appeal when we issue the reconsideration decision.Level 1 appealYou may request a Level 1 appeal, either verbally or in writing, if you are not satisfied with: The reconsideration decision (for claims disputes) An initial claim decisions based on medical necessity or experimental/investigational coverage criteria An initial precertification/patient management review decision We will notify you of our Level 1 decision in writing within 30 business days of our receipt of the appeal, unless we need additional information. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If the Level 1 appeal decision upholds our original position, we will send a written response. In the event that a member disagrees with a coverage determination, member may be eligible for the right to an internal appeal and/or an independent external appeal in accordance with applicable federal or state law. It may be necessary to forward claims payment issues involving reimbursement or coding reviews to a specialty unit for investigation and resolution. However, you may have more time if state regulations or your organizaional provider contract allows more time.To facilitate the handling of an issue, you should: State the reasons you disagree with our decision. For practitioners, the notice will include information about their right to request a review of the adverse determination as a Level 2 appeal. The dispute process DisputeA practitioner or organizational provider may submit a dispute in one of three ways: Write to the P.O. box listed on the Explanation of Benefits (EOB) statement, denial letter or overpayment letter related to the issue being disputed. Call our Provider Service Center at:-- 1-800-624-0756 for HMO-based benefits plans and WA Primary Choice plans-- 1-888-632-3862 for indemnity and PPO-based benefits plans Submit online through the EOB claim search tool – log in to the secure provider website via NaviNet®to access this tool. Utilization review: Issues relate to decisions made during the precertification, concurrent or retrospective review processes for services that require precertification. Examples include doctors, podiatrists and independent nurse practitioners.Organizational providers: Institutional providers and suppliers of health care services including behavioral health care organizations. You have 180 days from the date of the initial decision to submit a dispute. For appeals of a utilization review, medical necessity or experimental/investigational coverage criteria, a reviewer not associated with the Level 1 appeal will examine the Level 2 appeal. Claims payment disputes related to reimbursement or coding are subject to our reconsideration process. We will generally resolve claims payment issues related to contract application within three to five business days. For organizational providers, the notice will include our final determination. State laws do not apply to Medicare plans. Behavioral health organizations can be freestanding or hospital-based.Additionally, in networks where the Medicare product is offered, the organizational providers must include: laboratories, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, and providers of end-stage renal disease services.Dispute: A disagreement regarding a claim or utilization review decision.Reconsideration: A formal review of a previous claim payment decision as a result of an organizational provider/practitioner inquiry. If the decision is in your favor, we will recalculate and reprocess the claim for any services affected by the decision. GO TO: Select one option Dispute process and timeframes Reconsiderations versus appeals 2017 policy changes Definitions The following definitions apply in an insurance dispute: Practitioners:An individual who is licensed or otherwise authorized by the State to provide health care services. QuestionsIf you have questions about our appeal process, please contact our provider service center: 1-800-624-0756 for HMO-based benefits plans and WA Primary Choice plans 1-888-632-3862 for indemnity and PPO-based benefits plans The member's benefit plan determines coverage. This is the first step in disputing a claim payment decision. Members should discuss any matters related to their coverage or condition with their treating provider. We will notify you of our Level 2 appeal decision within 30 business days of our receipt of the appeal, unless we need additional information. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Aetna) for a particular member. Provide appropriate documentation to support your payment dispute (for example, a remittance advice from a Medicare carrier; medical records; office notes, etc.). Examples of organizational providers include, but are not limited to: hospitals, nursing homes; skilled nursing facilities (SNF), home care agencies, free standing surgical centers, birthing centers, urgent care centers, pain management centers, ambulance services, pharmacy, hospice, infusion centers, blood banks, diagnostic testing centers, diabetic treatment centers, residential treatment facilities, MRI centers, independent durable medical equipment vendors, orthotics facilities, oncology treatment centers, optical facilities, and sleep diagnostic center. A provider service center representative will research the handling of the claim in question. If the Level 1 appeal decision is in your favor, we will recalculate and reprocess the claim for any services affected by the decision. Organizational providers are not eligible for a Level 2 appeal, except as required by state regulations. State laws and regulationsTo the extent that our policy varies from the applicable laws or regulations of an individual state, the requirements of the state regulation apply and supersede our policy.State law does not supersede our policy in appeals relating to Aetna Medicare plans. Some plans exclude coverage for services or supplies that Aetna considers medically necessary. Have the denial letter, EOB statement or overpayment letter and the original claim available for reference. Medical necessity determinations in connection with coverage decisions are made on a case-by-case basis. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Aetna’s law department makes the final determination when there is any question as to the applicability of a law. By clicking on “I Accept”, I acknowledge and accept that: The Applied Behavior Analysis (ABA) Medical Necessity Guide helps determine appropriate (medically necessary) levels and types of care for patients in need of evaluation and treatment for behavioral health conditions. The ABA Medical Necessity Guide does not constitute medical advice. If an organizational provider/practitioner’s issue is eligible for the reconsideration, it takes place prior to the appeal process. Initial adverse claims decisions based on medical necessity or experimental or investigational coverage criteria are handled as Level 1 appeals and reviewed by clinicians. Please note also that the ABA Medical Necessity Guide may be updated and are, therefore, subject to change.

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