Dear Requestor:

You have requested services for medical treatment that needs to be reviewed to determine medical necessity.

In order to review your condition for medical necessity in a timely and complete manner, please provide all the following information:

- Completed enclosed questionnaire
- All required information as specified in the enclosed questionnaire

Please complete the questionnaire, submit a letter of medical necessity and return it to the address listed below, attention Managed Care Department. Please be advised that a letter of medical necessity without supporting medical documentation is not sufficient.

Our Medical Review Team makes a determination based on the information provided. Upon completion of the review, a written decision will be sent to the treating provider and patient. This decision is based on patient eligibility and benefit information available at the time of the review. Plan provisions will govern and payment will be based on patient eligibility and available benefits at the time services are rendered.

Please note the following:

- All complete medical necessity review requests MUST be received at least 15 business days prior to the proposed date of service.

- All information should be sent to:
  
  Aetna
  P.O. Box 14079
  Lexington, KY 40512-4079
  Fax: (860) 907-4656 or (859) 455-8650

Sincerely,

Aetna Student Health
Managed Care Department
AETNA STUDENT HEALTH
MEDICAL NECESSITY QUESTIONNAIRE

Please note: This form should be completed by your Treating Physician with ICD-10 & CPT4 codes to enable an appropriate determination.
If coding is not provided, this form will be returned as incomplete.

PATIENT INFORMATION
Last name: ______________________ First name: ______________________ MI: ______
Local address: ____________________________________________________________
Student ID#____________________ Daytime phone: (___)_____________________
DOB _______ School name: _______________________

DIAGNOSIS – PLEASE PRINT LEGIBLY
Please provide in space provided or on a separate piece of paper, a written description of conditions as well as appropriate ICD-10 coding. If treatment is related to an accidental injury, please provide complete accident details, including how, when and where the accident occurred.

□ ICD-10 ____________  □ ICD-10 ____________
□ ICD-10 ____________  □ ICD-10 ____________
□ ICD-10 ____________  □ ICD-10 ____________

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

RECOMMENDED COURSE OF TREATMENT – PLEASE PRINT LEGIBLY
Please provide, in space provided or on a separate piece of paper, a written description of the proposed treatment, including ordering of Durable Medical Equipment, recommendation for special Procedures/surgery, any follow-up procedures associated with the primary surgery. (Must include specific CPT codes):

□ CPT4 _________  □ CPT4 _________
□ CPT4 _________  □ CPT4 _________
□ CPT4 _________  □ CPT4 _________

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Date of proposed surgery/treatment: ______________________________
Date of first treatment/symptom _________________________

TYPE OF SERVICE/STAY
□ INPATIENT (OVER 23 HOURS)  □ HOME CARE
□ AMBULATORY/OBSERVATION (UNDER 23 HOURS)  □ DME
□ OFFICE  □ INJECTIBLE REQUEST

□ OTHER SERVICE, TREATMENT OR PROCEDURE

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REV 10/1/2015
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MEDICAL RECORDS
Copies of medical records:

_____ Legible copies of all medical records _____ Laboratory _____ Pathology
_____ Actual imaging studies (CT films) _____ Cephalometric X-ray/Tracing (jaw surgery)
_____ Diagnostic study models (jaw surgery)
_____ Radiology reports (nasal/sinus surgery)
_____ Preoperative photos (all plastic surgery, including breast surgery/rhinoplasty)
_____ Other information; please specify: __________________________________________________

TREATING PHYSICIAN INFORMATION – PLEASE PRINT LEGIBLY

Name of treating physician: _______________________________________________________
Address: _____________________________ City: __________________ State: ______ Zip: ______
Phone number: ______________________ Fax number: __________________________
Specialty: _____________________________________________________________
Health center or other contact: ______________________ Contact fax number: __________

HOSPITAL OR FACILITY WHERE SERVICES ARE TO BE PERFORMED

Hospital/facility: _____________________________
Address: _____________________________ City: __________________ State: ______ Zip: ______
Phone number: _____________________________

A written response will be sent to the treating physician and the patient upon completion of the reviews. This determination is based on the eligibility and benefits available at the time of the review. Plan provisions will govern and payment will be based on eligibility and available benefits at the time services are rendered. If you disagree with the determination, please follow the appeals/reconsideration process as outlined in the brochure.

Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Self-insured plans are funded by the applicable school, with claims administration services provided by Aetna Life Insurance Company. Aetna Student Healthsm is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

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