

# Gender Reassignment Surgery Aetna Student Health Precertification Information Request Form

## About this form

**You can't use this form to initiate a precertification request.** To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically.

Effective **April 18, 2016**, this form replaces all other gender reassignment surgery 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. You can send it via confidential fax to **860-907-4656**.

## 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 #615: Gender Reassignment Surgery**, before you complete this form. You can find the policy 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:

- HMO plans: **1-800-624-0756**
- Traditional plans: **1-888-632-3862**

**Section 1: Provide the following general information**

<b>Member name:</b>	<b>Administrative reference number (required):</b>
<b>Member ID:</b>	<b>Member date of birth: (Must be 18 years of age or older)</b>
<b>Requesting provider/facility name:</b>	
<b>Requesting provider/facility phone number:</b> 1-    -    -	
<b>Requesting provider/facility fax number:</b> 1-    -    -	
<b>Assistant/co-surgeon name (if applicable):</b>	<b>TIN:</b>
<b>Referral on file, if applicable, with Student Health Center and Aetna Student Health?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

**Section 2: Provide the following patient-specific information.**

Is this a new or continued treatment?     New     Continued

Does the member have persistent, well-documented gender dysphoria?     Yes     No

Does the patient have the capacity to make a fully informed decision and to consent for treatment?     Yes     No

Does the patient currently have significant medical or mental health concerns?     Yes     No

If yes, are they reasonably well controlled?     Yes     No

Is the request for female-to-male services?     Yes     No    **If yes, go to Section 3.**

Is the request for male-to-female services?     Yes     No    **If yes, go to Section 4.**

**Section 3: Complete this section if request is for female-to-male services**

**Select the requested service(s):**

**Mastectomy**

Does the patient have one referral letter from a qualified mental health professional?     Yes     No

**Gonadectomy** (hysterectomy and oophorectomy)

Does the patient have two referral letters from qualified mental health professionals, one in a purely evaluative role?     Yes     No

Does the patient have 12 months of continuous hormone therapy appropriate for their gender goals?     Yes     No

If no, does the patient have a contraindication or is otherwise unable or unwilling to take hormones?     Yes     No

**Genital reconstructive surgery** (vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, placement of a testicular prosthesis and erectile prosthesis)

Does the patient have two referral letters from qualified mental health professionals, one in a purely evaluative role?     Yes     No

Does the patient have 12 months of continuous hormone therapy appropriate for their gender goals?     Yes     No

If no, does the patient have a contraindication or is otherwise unable or unwilling to take hormones?     Yes     No

Has the patient been living in a gender role that is congruent with their gender identity (real-life experience) for 12 months?     Yes     No

**Submit all applicable medical records.**

**Section 4: Complete this section if request is for male-to-female services**

**Select the requested service(s):**

**Orchiectomy**

- Does the patient have two referral letters from qualified mental health professionals, one in a purely evaluative role?  Yes  No
- Does the patient have 12 months of continuous hormone therapy appropriate for their gender goals?  Yes  No
- If no, does the patient have a contraindication or is otherwise unable or unwilling to take hormones?  Yes  No

**Genital reconstructive surgery** (penectomy, vaginoplasty, labiaplasty and clitoroplasty)

- Does the patient have two referral letters from qualified mental health professionals, one in a purely evaluative role?  Yes  No
- Does the patient have 12 months of continuous hormone therapy appropriate for their gender goals?  Yes  No
- If no, does the patient have a contraindication or is otherwise unable or unwilling to take hormones?  Yes  No
- Has the patient been living in a gender role that is congruent with their gender identity (real-life experience) for 12 months?  Yes  No

**Submit all applicable medical records.**

**Section 5: Provide the following documentation for your request**

- Current history and physical
- Office notes related to the patient's condition
- Description of proposed treatment
- Mental health referral letter(s)
- Documentation of mental health conditions, if applicable
- Documentation of hormone therapy, including duration, if applicable

**Section 6: 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 7: Sign the form**

**Just remember: You can't use this form to initiate a precertification request.** To initiate a request, you have to call our Precertification Department. Or you can submit your request electronically.

**Form completed by:**

**Title:**