Aetna® Medicare FIDE (HMO D-SNP)
PO Box 818051
Cleveland OH 44181-8051
Phone: **1-866-600-2139 (TTY: 711)**
Fax: 1-855-320-8445

Health plan website: AetnaMedicare.com/ILDSNP

Prior authorization request form

About this form: Failure to complete this form and submit all medical records related to the request may result in the delay of review or denial of coverage.

How to fill out this form: Use this form only for the Aetna Medicare FIDE (HMO D-SNP) health plan. The requesting physician and/or provider must complete all sections of this form.

When you're done

Once you've filled out the form, submit it and all medical documentation to support your request to our Prior Authorization Department via:

- Our free provider portal, Availity Essentials (our preference). You can use it in place of this form to start, update, upload clinical and check the status of a prior authorization Please visit Availity.com/aetnaproviders to register.
- Confidential fax to <**1-855-320-8445>.**
- Electronic Data Interchange (EDI) or by calling us at <**1-866-600-2139 (TTY: 711)>** to expedite requests.

What happens next?

We'll perform a clinical review once we receive the request with documentation. Then we'll make a coverage determination and let you know a decision.

How we make coverage determinations

To support coverage decisions, we use nationally recognized clinical guidelines and resources, such as:

- Medicare National Coverage Determinations (NCD)
- Medicare Local Coverage Determinations (LCD)
- Medicare Benefit Policy Manual
- Other applicable Medicare requirements
- Aetna supplemental policies

You can find Aetna supplemental policies on our Health Plan website, **AetnaMedicare.com/ILDSNP**

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PRIOR AUTHORIZATION FORM for **Aetna® Medicare FIDE (HMO D-SNP)**

Date of Request: _____

MEMBER INFORMATION

Name: _____ID Number _____
Date of Birth: _____
Gender (circle one): F M
Member's Primary Care Physician: _____

Ordering/Referring Provider
Name:
Address:
Telephone:
Fax:
NPI Number:
Contact Person:

****Requesting Provider-Who is requesting/submitting the service authorization request to Aetna Medicare FIDE (HMO D-SNP)**
Name:
Address:
Telephone:
Fax:
NPI Number:
Contact Person:

Place of Service, Facility Name or Servicing Provider
Name:
Address:
Telephone:
Fax:
NPI Number:
Contact Person:

Type of Procedure (circle one): Inpatient ☐ Outpatient ☐ DME ☐ Medicare Part B Drug ☐
Diagnosis/ICD-10 Code(s):
Procedure /Item Requested (CPT/HCPCS Code(s)):
Date (or Span) of Appointment or Service: Start Date_____ End Date_____
Number of Visits/Qty Required: _____