200 Rivers Edge Drive
Medford, MA 02155
Tel: 1-781-219-9100
Fax: 1-860-907-4656
www.aetnastudenthealth.com

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 20 business days prior to the proposed date of service.

- All information should be sent to:

  Aetna Student Health
  Attn: Managed Care
  200 Rivers Edge Drive
  Medford, MA 02155
  Fax: 1-860-907-4656

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 ICD9 & 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: _____
Social Security/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-9 coding. If treatment is related to an accidental injury, please provide complete accident details, including how, when and where the accident occurred.

☐ ICD9 _____ ☐ ICD9 _____

☐ ICD9 _____ ☐ ICD9 _____

☐ ICD9 _____ ☐ ICD9 _____

_____
_____
_____
_____
_____

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

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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 PRFORMED

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) and administered by Chickering Claims Administrators, Inc. (CCA). Self-insured plans are funded by the applicable school, with claims administration services provided by CCA. Aetna Student Health℠ is the brand name for products and services provided by Aetna and CCA and their applicable affiliated companies.