Instructions for Submitting Requests for Predeterminations

Meritain Health®
an aetna company

Complete and return to:
Meritain Health®
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.716.541.6735
Email: predetermination@meritain.com

REQUEST FOR INFUSION DRUG AUTHORIZATION
THIS IS A COURTESY REVIEW AND NOT A PRE-CERTIFICATION OF BENEFITS

PLEASE NOTE: sending anything other than a predetermination request will delay the review of your information.

IMPORTANT PREDETERMINATION REMINDERS

1. Always verify eligibility and benefits first.
2. All applicable fields are required. If all information is not provided, this may cause a delay in the predetermination process. (Inquiries received without the member/patient's group number, ID number, and date of birth cannot be completed and may be returned to you to supply this information.)
3. Fax information for each patient separately, using the fax number indicated on the form.
4. Always place the Predetermination Request Form on top of other supporting documentation. Please include any additional comments if needed with supporting documentation.
5. Do not send in duplicate requests, as this may delay the process.
6. If photos are required for review, the photos should be mailed along with the Predetermination Request Form and not faxed. Faxed photos are not legible and cannot be used to make a determination.

Please note: The fact that a guideline is available for any given treatment or that a service or treatment has been preauthorized or predetermined for benefits, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and plan provisions in effect at the time the service is rendered.

Please note: Attach all clinical documentation to support medical necessity. The patient's plan document supersedes this and Aetna® clinical policy bulletin criteria.

How to fill out this form
As the patient's attending physician, you must complete all sections of the form.

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.

SECTION 1: PROVIDE THE FOLLOWING GENERAL INFORMATION	
MEMBER NAME	MEMBER DATE OF BIRTH
MEMBER ID NUMBER	
REQUESTING PROVIDER/FACILITY NAME	PROVIDER ADDRESS
PROVIDER PHONE NUMBER	PROVIDER FAX NUMBER

SECTION 2: PROVIDE THE FOLLOWING PATIENT-SPECIFIC INFORMATION	
PATIENT'S PLAN DOCUMENT SUPERSEDES THIS AND AETNA CLINICAL POLICY BULLETIN CRITERIA	
MEMBER NAME	MEMBER ID NUMBER
GROUP NAME	GROUP NUMBER
PATIENT NAME	PATIENT DATE OF BIRTH
PROCEDURE CODE(S)	PRICE (INDICATE IF PER UNIT OR FULL PRICE)
DIAGNOSIS CODE(S)	
PLEASE SELECT WHICH IS APPLICABLE ☐ HOME INFUSION ☐ OFFICE/INFUSION CENTER ☐ REQUESTING BUY AND BILL	

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