Aetna Better Health® of Illinois
PO Box 818031, MC F661
Cleveland, OH 44181-8031

Aetna Better Health® of Illinois

Durable medical equipment (DME) benefit verification and authorization

Aetna Better Health® of Illinois issues this notice to support providers who bill for services listed on the **HFS Durable Medical Equipment (DME) Fee Schedule**. This includes but is not limited to prosthetics, orthotics, audiology and home infusion.

Is prior authorization required?

Before rendering services, providers should complete all steps listed below to determine whether prior authorization is required. This helps ensure claims are accurately processed in a timely manner. Failure to complete the steps could result in claim denials.

- ✓ Verify if any services require prior authorization using the **Prior Authorization Search tool** available on the **Prior Authorization page** of our provider website. If the tool indicates prior authorization is required, one must be obtained.
- ✓ Determine the HFS allowable max units on the **HFS website**. If the number of units being requested exceeds the max units listed, prior authorization must be obtained.
- ✓ Verify whether the member has already exceeded the HFS allowable max units using the Audiology and DME Benefit Maximum Verification Process. You can do this by completing the **Audiology & DME Benefit Maximum Verification Form**, available on the **Provider Forms page** of our provider website. If it's determined that the member has already or will exceed their allowed benefits, prior authorization must be obtained.

Please note: the Availity web portal does not currently offer the ability to consider the number of units being requested in relation to the number of units already used by a member.

Requesting prior authorization

To request prior authorization for DME services, complete the Aetna Better Health® of Illinois **Prior Authorization Request Form**. At the top of the form, please indicate "Request for prior authorization exceeds HFS allowable max units".

Aetna Better Health® of Illinois
3200 Highland Ave, MC F648
Downers Grove, IL 60515

Request for Prior Authorization

EXCEEDS HFS allowable max units

aetna™

Aetna Better Health® of Illinois

Prior Authorization Request Form

Phone: **1-866-329-4701**/Fax: **1-877-779-5234**

For urgent outpatient service requests (required within 72 hours) call us.

Did you know that you can use our provider portal Availity® to submit prior authorization request, upload clinical documentation, check statuses, and make changes to existing requests? Register today at www.Availity.com

Submit the completed Prior Authorization Request Form — along with any applicable medical records — by fax to **1-877-779-5234**.

We're here to help

We've included the forms you can use to determine if prior authorization is necessary and to request prior authorization.

For additional support with member benefits and prior authorization, please call our health plan at **1-866-329-4701.**

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Audiology & DME Benefit Maximum Verification

This form should be used to confirm whether the max HFS benefits have been used for Audiology or Durable Medical Equipment services. Please complete the below fields, the information provided by Aetna better Health of Illinois is only current and accurate as of the date of receipt.

Please complete the below form and e-mail to benefitLimitVerification@AETNA.com.

Date of Request: _____

MEMBER INFORMATION

Name: _____

Medicaid ID Number _____

Member's Date of Birth: _____

PROVIDER INFORMATION

Provider Name: _____

TIN **(Required*)** _____

Email Address: _____

Contact Telephone #: _____

Contact Person: _____

Audiology / DME Service Requested:

CPT / HCPCS code(s):	Expected Delivery Date:	Expected Number of Units:

**The below table will be completed by the health plan*

CPT / HCPCS code(s):	Prior Auth Required Y or N	HFS Max Limit:	HFS Max Days:	Date of Service:	Units Used:

*NOTE: **The above information is determined by claims received and adjusted**.

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Prior Authorization Request Form

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Date of Request:_____

MEMBER INFORMATION

Name:_____ID Number _____

Date of Birth:_____PCP Name: _____

Other Insurance ? / Policy Holder / Policy Number: _____

Gender (circle one): ◯ **F** ◯ **M**

PROVIDER INFORMATION

Ordering/Requesting Provider:

Name:_____

NPI **(Required*)**_____

Address:_____

Telephone #:_____

Fax #:_____

Contact Person: _____

Servicing Provider/Facility/Specialist:

Name:_____

NPI **(Required*)** _____

Address:_____

Telephone #: _____

Fax #: _____

Specialty:_____

AUTHORIZATION INFORMATION

Diagnosis/ICD-10 Code(s) (Required*)

1. _____ 2. _____ 3._____ 4._____ 5. _____

Service/Procedure requested (CPT or HCPCS codes Required*):

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

Type of Procedure/Level of care (circle one): ◯ **Inpatient** ◯ **Outpatient** ◯ **In Office**

Date(s) of service:_____**Number of visits/units:**_____

REQUIRED DOCUMENTATION

Include supporting pertinent clinical information (Required*) ---*5 pages or less*--- (e.g clinical/progress notes, lab/imaging reports, plan of care, letter of medical necessity, etc).

***NOTE: FAILURE TO INCLUDE NPI NUMBERS, DIAGNOSIS, CPT/HCPCS CODES AND SUPPORTING CLINICAL INFORMATION WILL RESULT IN THE RETURN OF THIS FORM UNPROCESSED.**