Aetna Assure Premier Plus (HMO D-SNP)
7400 West Campus Rd.
New Albany, OH 43054
1-844-362-0934

AETNA® ASSURE PREMIER PLUS (HMO D-SNP)

Electronic Visit Verification service authorization request form

In Home Services Only: Personal Care Service (PCA), Skilled Nursing, Private Duty Nursing, Home Health, & Therapies

☐ **Check here to confirm the services are being provided in the home (POS12)**

Fax completed form to 1-833-322-0034

☐ **Adult request** ☐ **Pediatric request**

Please check type of request:

☐ **Initial request** ☐ **Re-authorization request** ☐ **Facility/Provider transfer**
☐ **Change in Managed Care Organization**

Date submitted to Aetna Assure Premier Plus (HMO D-SNP): _____

Please provide the following member demographic information:

Member name: _____

Aetna Assure Premier Plus (HMO D-SNP) Member ID #_____ DOB: _____

Member address *(Street/City)* _____

Member phone number: _____ Alternative phone number: _____

Translation needed: ☐ YES / ☐ NO If yes - language: _____

Member Email address: _____

Please provide the following information:

Current authorization expires on: _____

Requesting # days per week: _____ Requested number of hours/units per week: _____

Has the member had a lapse in service for 30 consecutive days during the prior authorization period? ☐ YES / ☐ NO

Is there another Aetna member receiving services in the home? ☐ YES / ☐ NO

Name:_____ Aetna ID:_____ DOB:_____

Primary DX: _____ ICD-10 _____ Other Chronic Dx_____

To facilitate the service authorization process, please include the following information: physician/ PCP orders, previous authorization if transferring from another health plan and a copy of the most recent assessment if available.

Please enter the appropriate code and description associated to the service need:_____

_____

Service Request Type:	☐ New ☐ Continuation of current hours/days ☐ Increase in Hours/Days ☐ Decrease in Hours/Days
Information to support service request: *(*Physician order required for all initial request, and increase/decrease in hours/ days)	☐ Physician Order Form ☐ Previous HMO Authorization Form ☐ Most recent Assessment if Available

Required additional information*:*

Provider name:			
Provider ID#:			
Facility address:			
Facility phone #:		Facility Fax #:	

All services on this form require prior authorization, and must be conducted in the patient's home setting. Aetna Assure Premier Plus (HMO D-SNP) may require additional clinical information on a case-by-case basis. Please submit request for continued service no more than 30 days prior to current authorization end-date. All pages of the request form must be completed.