Medical Necessity and Prior Authorization

Medical Necessity Reviews (Aetna members/providers only)

I received an Explanation of Payment (EOP) requesting medical records. Where should I send them?
Please fax the requested medical records to: 888-398-3055.

I received a Medical Record Request Letter from the Gravie Appeals Team. Where should I send the records?
Please fax medical records requested by the Appeals Team to: 888.977.1856

The Gravie Care® Team asked me to submit medical records. Where should I send them?
Please fax medical records requested by the Gravie Care® Team to: 888-398-3055

I was asked to submit medical records to support a medical necessity review. What documentation is required?
To support a medical necessity review, please submit documentation that clearly demonstrates the patient's diagnosis and the clinical rationale for the requested service. As applicable, include:

- A signed order or referral for the service, procedure, or equipment
- Provider notes or progress notes, including history and physical, documenting the patient's symptoms, diagnosis, condition, and clinical justification. Please include the most recent and relevant notes near the date of service
- Diagnostic test results, such as lab reports or imaging, that support the requested service
- Procedure reports, if the service has already been performed
- Consultation reports, if applicable

Documentation must demonstrate that the service is appropriate, medically necessary for the patient's condition, and consistent with generally accepted standards of care.

Is Gravie itself performing the medical necessity review on behalf of my patient?
Gravie partners with American Health Holdings (AHH) to conduct prior authorizations, medical necessity reviews, and related appeals.

- For **active Gravie members,** providers should contact AHH directly to initiate prior authorization or requests for pre-service medical necessity reviews.
- For **terminated Gravie members**, requests must be submitted to Gravie first. Gravie will triage the request and forward the medical records to AHH for review and determination.

I submitted medical records. How long does it take to receive a determination?

- If the service has **not yet been performed**, the review may take up to **15 calendar days**. However, Urgent prior authorization requests will be decided sooner.
- If the service has **already been performed**, the review may take up to **30 calendar days**. Please note that if the appeals team is requesting records for an appeal, turnaround will be in accordance with ERISA appeals decision timeframes.

How will I receive the medical necessity determination?

Determinations are mailed to the provider address listed in our provider directory. Please allow 7 to 10 days for delivery. A copy of the determination is also sent to the member. An electronic copy can be provided upon request.

Prior Authorizations

I need to obtain a Prior Authorization for an active Gravie member. What are my next steps?

1. Review the Prior Authorization requirements at: https://www.gravie.com/providers/claims/
2. If the CPT/HCPCS code appears on the list, contact AHH at [contact information] to request prior authorization.
3. If the code does not appear on the list, prior authorization is not required.

Please note that all services remain subject to medical necessity requirements. Providers who would like a voluntary pre-service medical necessity review may contact the Gravie Care® Team at the phone number listed on the back of the member's ID card.

How do I request a retroactive prior authorization for an active Gravie member?

Please visit the Gravie website at: https://www.gravie.com/providers/ for instructions on submitting a retroactive prior authorization request.

How do I request a retroactive prior authorization for a member who is now terminated but was active on the date of service?

Please contact the Gravie Care® Team at the phone number listed on the back of the member's ID card to confirm the member's eligibility status. If the member is confirmed to be terminated, the Gravie Care® representative will provide instructions on how to submit the retroactive authorization request.

I submitted a claim that was denied due to lack of information needed to determine medical necessity. What are my next steps?

If the EOP does provide instructions for next steps to determine whether the services rendered were medical necessity, please follow the instructions supplied. However, if the EOP does not specifically provide instructions for next steps to determine whether the services rendered were medical necessity, please call the provider services phone number on the back of the member's ID card to initiate the process.