Aetna Medicare HIDE (HMO D-SNP)
PO Box 818051
Cleveland, OH 44181-8051
Phone: 1-855-676-5772

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Medical day care/personal care attendant service authorization request form

Fax completed form to 1-844-241-2495:

☐ Adult ☐ Pediatric

Please check type of request:

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

Date submitted to Aetna Medicare HIDE (HMO D-SNP): _____

Please provide the following demographic information:

Member name: _____

Aetna Medicare HIDE 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 member had a lapse in service for 30 consecutive days during the prior authorization period?

☐ Yes / ☐ No

Primary DX: _____ ICD-10 _____ Other Chronic DX_____

Please check one of the following codes:

☐ PCA T1019 ☐ Pediatric Medical Day (technologically dependent) T1024 w/modifier 22

☐ Adult Medical Day S5102 ☐ Pediatric Med Day (medically fragile) T1024 w/modifier 5

Transportation provided?

☐ Yes ☐ No

Services provided:

☐ Eating ☐ Med Administration

☐ Bathing/Dressing ☐ Transferring

☐ Grooming ☐ Telephoning

☐ Continence ☐ Supervision

☐ Meals ☐ Other

Other: _____

Number of days services provided: _____

Month/Year: _____

Change in service request:

Information to support service request change *(must provide specifics):*_____

_____

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

Service Request Type:	☐ New ☐ Continuation of current hours/days ☐ Increase in Hours/Days ☐ Decrease in Hours/Days
Information to support service request change *(Specific information required)*	☐ Physician Order Form ☐ Previous HMO Authorization Form ☐ Most recent Assessment if Available

Required additional information*:*

Medical day care /personal care assistant service provider name:	
Provider ID# (NPI):	
Facility address:	

Facility phone #:		Facility Fax #:	

All medical day care services and PCA services require prior authorization. Aetna Medicare HIDE 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. Both pages of request form must be completed.