# Aetna Better Health® of Texas

Please complete this form and submit along with the member's clinical information to Aetna Better Health® of Texas Utilization Management (UM) Department at:

**FAX**: 1-855-841-8355

Submitter Name:

Facility/Provider Title

Member's Name:

Member's Medicaid ID Number:

Member's Date of Birth (MM/DD/YYYY):

Date member was educated on In Lieu of Service (ILOS):

Document member's decision on receiving ILOS:

- ☐ Agrees to Coordinated Specialty Care (CSC)
- ☐ Agrees to Partial Hospitalization Program (PHP)
- ☐ Agrees to Intensive Outpatient Program (IOP)
- ☐ Declines In Lieu of Services (ILOS)


©2026 Aetna Inc. Proprietary