Behavioral Health Inpatient Form

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Telephone: **1-844-835-4930**
Please upload this form and supporting documentation to https://apps.availity.com

A determination will be communicated to the requesting provider

- Incomplete requests will delay the prior authorization process.
- Please include pertinent chart notes to expedite this request.

Type of Request

☐ **URGENT** (For requests received after the member has been admitted to the facility, a response will be given within 3 calendar days)
☐ **PRE-SERVICE** (For requests received before admission to the facility, a response will be given within 5 business days)

☐ **ACUTE BH**
☐ **INPATIENT PRTF**
☐ **SUBACUTE BH**

Patient Information

Patient Name: (Last, First, MI)		Date of Birth: / /
I.D. Number:	Gender: ☐ Male ☐ Female	EPSDT special service request?
Other Insurance? ☐ Yes ☐ No	Name of Carrier	
Job Related? ☐ Yes ☐ No	MVA? ☐ Yes ☐ No	Is the member currently pregnant? ☐ Yes ☐ No

From: Requesting Provider

Requesting Provider (Please Print):		Tax ID Number:
Contact Person in Requesting Provider's Office:	Telephone: ( )	Fax: ( )
WV Medicaid Provider Number:	Clinical Contact Person: Phone: ( )	Name of PCP:

To: Where Will Member Receive Services?

Physician / Provider / Facility Requested:	Address:	
Telephone: ( )	Fax: ( )	
Where services will be rendered? (Provide name of facility, if other than provider office or patient's home)		
WV Medicaid Provider Number:	Today's Date: / /	Tentative Date of Service / Admission: / /
Were member school-based services interrupted? ☐ Yes ☐ No	Start Date: / /	End Date: / /

Clinical Information

ICD-10 Codes: (required) 1 _____ 2 _____ 3 _____ 4 _____	ICD-10 Description:
REVENUE CODES: (required)	REVENUE Description:
Comments (List number of Days / Visits / Units or if services are needed at discharge):	

Clinical Indications / Rationale for Request:
To expedite a determination on your request for services, please attach clinical documentation/medical records to support your request. Please include the following: Conservative treatment tried and failed, applicable diagnostic testing with results and lab values and a medication list.

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