

AETNA BETTER HEALTH® PREMIER PLAN MMAI

Prior Authorization Request Form Phone: 1-866-600-2139 (Premier Plan), Fax: 1-855-320-8445, Fax: 1-855-687-6955 (for Inpatient use)

PLEASE NOTE: Our free provider portal (Availity Essentials) may be used in place of this form to start, update, and check the status of a Prior Authorization. Please visit <u>www.availity.com/aetnaproviders</u>

Date of Request:	For urgent outpatient service requests (req	juired within 72 hours) call us.
31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 12 Home 11 Office MEMBER INFORMATION Name:	Date of Request:	
MEMBER INFORMATION Name:	PLACE OF SERVICE	
Name: ID Number Date of Birth: PCP Name: Other Insurance? / Policy Holder / Policy Number:	□ 31 Skilled Nursing Facility □32 Nursing Facility	acility \Box 33 Custodial Care Facility \Box 12 Home \Box 11 Office
Name: ID Number Date of Birth: PCP Name: Other Insurance? / Policy Holder / Policy Number:		
Date of Birth:		
Other Insurance? / Policy Holder / Policy Number: Gender (circle one): F Marce Servicing Provider/Facility/Specialist: Name: Name: Name: Name: Ner Name: NPI (Required*) NPI (Required*) Address: Address: Telephone #: Fax #: Contact Person: Speciality: AUTHORIZATION INFORMATION Diagnosis/ICD-10 Code(s) (Required*) 1. 2. 3. 6. 9. Type of Procedure / Level of care (circle one): Inpatient Outpatient		
Gender (circle one): F M PROVIDER INFORMATION Servicing Provider/Facility/Specialist: Name: Name: Name: Name: Name: Name: NPI (Required*) NPI (Required*) NPI (Required*) Address: Address: Address: Telephone #: Telephone #: Telephone #: Fax #: Fax #: Contact Person: Specialty: AUTHORIZATION INFORMATION Specialty: Specialty: Specialty: AUTHORIZATION INFORMATION 1 2. 3. 4. 5. Specialty: Service/Procedure requested (CPT or HCPCS codes Required*): 1. 7. Specialty: Specialty:		
PROVIDER INFORMATION Ordering/Requesting Provider: Servicing Provider/Facility/Specialist: Name: Name: Name: Name: NPI (Required*) NPI (Required*) Address: Address: Telephone #: Telephone #: Fax #: Fax #: Contact Person: Specialty: AUTHORIZATION INFORMATION Diagnosis/ICD-10 Code(s) (Required*) 1	Other Insurance? / Policy Holder / Policy Nur	mber:
Ordering/Requesting Provider: Servicing Provider/Facility/Specialist: Name: Name: Name: Name: NPI (Required*) NPI (Required*) Address: Address: Telephone #: Telephone #: Fax #: Fax #: Contact Person: Speciality: AUTHORIZATION INFORMATION Diagnosis/ICD-10 Code(s) (Required*) 1 2. 3. 4. 5. 3. 6. 9. Type of Procedure/Level of care (circle one): Inpatient Outpatient	Gender (circle one): F M	
Ordering/Requesting Provider: Servicing Provider/Facility/Specialist: Name: Name: Name: Name: NPI (Required*) NPI (Required*) Address: Address: Telephone #: Telephone #: Fax #: Fax #: Contact Person: Speciality: AUTHORIZATION INFORMATION Diagnosis/ICD-10 Code(s) (Required*) 1 2. 3. 4. 5. 3. 6. 9. Type of Procedure/Level of care (circle one): Inpatient Outpatient		
Name:		
NPI (Required*) NPI (Required*) Address: Address: Telephone #: Telephone #: Fax #: Fax #: Contact Person: Specialty: AUTHORIZATION INFORMATION Diagnosis/ICD-10 Code(s) (Required*) 1. 2. 3. 6. 9. Type of Procedure /Level of care (circle one): In patient		
Address:		
Telephone #:		
Fax #:		
Contact Person:		
AUTHORIZATION INFORMATION Diagnosis/ICD-10 Code(s) (Required*) 1. 3. 2. 3. Service/Procedure requested (CPT or HCPCS codes Required*): 1. 4. 2. 5. 3. 6. 9.		
Diagnosis/ICD-10 Code(s) (Required*) 1. 2. 3. 4. 5.		Specialty:
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Service/Procedure requested (CPT or HCPCS codes Required*): 1. 4. 7. 2. 5. 8. 3. 6. 9.	1 2	2 4 5
1. 4. 7. 2. 5. 8. 3. 6. 9.	ı 2	3 4 5
2. 5. 8. 3. 6. 9. Type of Procedure/Level of care (circle one): Inpatient Outpatient In Office	Service/Procedure requested (CPT or HCP	PCS codes Required*):
3. 6. 9. Type of Procedure/Level of care (circle one): Inpatient Outpatient In Office	1 4	7
3. 6. 9. Type of Procedure/Level of care (circle one): Inpatient Outpatient In Office	2 5	8
	36	9
Date(s) of service: Number of visits/units:	Type of Procedure/Level of care (circle one	e): Inpatient Outpatient In Office
	Date(s) of service:	Number of visits/units:
	REQUIRED DOCUMENTATION	

Include supporting pertinent clinical information (Required*) ---5 pages or less--- (e.g clinical/progress notes, lab/imaging

reports, plan of care, letter of medical necessity, etc). *NOTE: <u>FAILURE TO INCLUDE NPI NUMBERS, DIAGNOSIS, CPT/HCPCS CODES AND SUPPORTING CLINICAL INFORMATION</u> <u>WILL RESULT IN THE RETURN OF THIS FORM UNPROCESSED.</u>

Created: 11/10/2010 Revised 8/11/2022

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