AETNA BETTER HEALTH® OF ILLINOIS

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

For urgent outpatient service requests (required within 72 hours) call us.

Date of Request: _____

MEMBER INFORMATION

Name: _____ ID Number _____

Date of Birth: _____PCP Name: _____

Other Insurance ? / Policy Holder / Policy Number: _____

Gender (circle one): **F** **M**

PROVIDER INFORMATION

Ordering/Requesting Provider:

Name: _____

NPI **(Required*)** _____

Address: _____

Telephone #: _____

Fax #: _____

Contact Person: _____

Servicing Provider/Facility/Specialist:

Name: _____

NPI **(Required*)** _____

Address: _____

Telephone #: _____

Fax #: _____

Specialty: _____

AUTHORIZATION INFORMATION

Diagnosis/ICD-10 Code(s) (Required*)

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Service/Procedure requested (CPT or HCPCS codes Required*):

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Type of Procedure/Level of care (circle one): **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:** **FAILURE TO INCLUDE NPI NUMBERS, DIAGNOSIS, CPT/HCPCS CODES AND SUPPORTING CLINICAL INFORMATION WILL RESULT IN THE RETURN OF THIS FORM UNPROCESSED.**