Submit to:
Aetna Better Health of Illinois UM
Phone 1-866-239-4701/Fax 1-844-528-3453

BH MOBILE CRISIS NOTIFICATION FORM

Please print clearly – incomplete or illegible forms will delay processing. ALL SECTIONS MUST BE COMPLETED.

Date_____

MEMBER INFORMATION

Name_____

DOB _____

Member ID #_____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID #_____

Provider/Agency NPI Sub Provider #_____

Phone_____Fax _____

CURRENT ICD DIAGNOSIS

Primary_____

Secondary_____

Tertiary_____

Additional_____

Additional _____

Has contact occurred with family? Yes ☐ No ☐

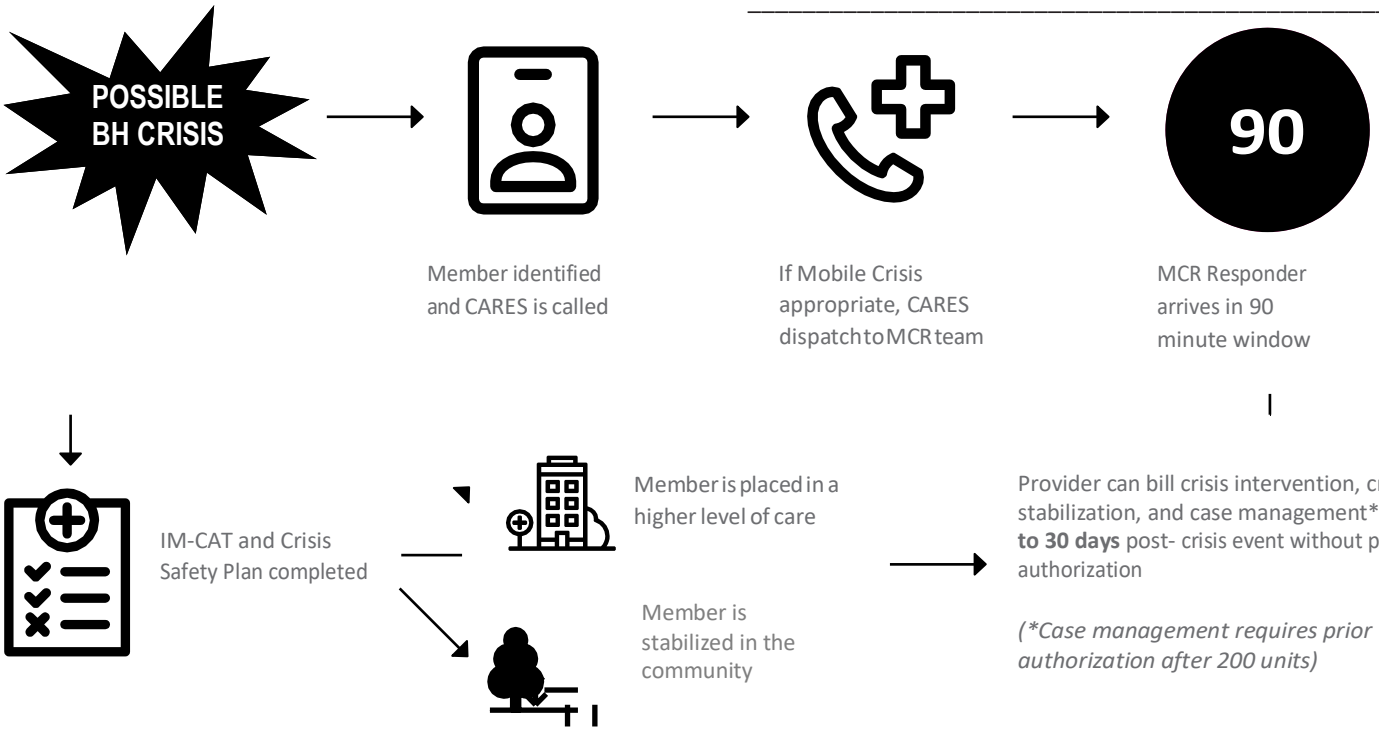
Time of call by provider/agency_____

Time of assessment by provider/agency_____

IP Appropriate Hospital ☐ Yes ☐ No

If no, date/time/name of 24-hour follow-up appointment:

_____



Scan the QR code to view virtual provider options for member follow-up.

AetnaBetterHealth.com/Illinois-Medicaid

IL-20-07-21

Revision 7/2025

Clinician Signature Date

Clinician Signature Date

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PLEASE ATTACH: IM–CAT and crisis stabilization plan