PHYSICAL HEALTH STANDARD PRIOR AUTHORIZATION REQUEST

TELEPHONE: 1-844-835-4930

AETNA BETTER HEALTH OF WEST VIRGINIA
500 VIRGINIA STREET EAST, SUITE 400
CHARLESTON, WV 25301
TELEPHONE NUMBER: 1-844-835-4930
TTY: 711

DATE OF REQUEST (MM/DD/YYYY):

Did you know that you can use our provider portal Availity® to submit prior authorization request, upload clinical documentation, check statuses, and make changes to existing requests? Register today at www.Availity.com

TYPE OF REQUEST: ☐ INPATIENT ☐ OUTPATIENT ☐ IN OFFICE

☐ URGENT – A request for medical care or other services for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following: 1) could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state or 2) in the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request. Urgent requests will be processed within 2 calendar days.

☐ NON-URGENT STANDARD – Routine services processed within 5 business days.

VISIT OUR PROPAT SEARCH TOOL TO DETERMINE IF A SERVICE REQUIRES PA https://medicaidportal.aetna.com/propat/Default.aspx.
A DETERMINATION WILL BE COMMUNICATED TO THE REQUESTING PROVIDER.

MEMBER INFORMATION		
1. LAST NAME:	2. FIRST NAME:	3. MI:
4. MEMBER AETNA ID # (*REQUIRED*):	5. DATE OF BIRTH (MMDDYYYY) (*REQUIRED*):	6. MEMBER'S PCP:

7. PCP PHONE NUMBER (xxx-xxx-xxxx):	8. PCP FAX NUMBER (xxx-xxx-xxxx):
9. GENDER: ☐ MALE ☐ FEMALE ☐ OTHER	10. IS THE MEMBER PREGNANT? ☐ YES ☐ NO
11. EPSDT SPECIAL SERVICE REQUEST? ☐ YES ☐ NO	12. MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO
13. COURT ORDERED? ☐ YES ☐ NO	14. JOB RELATED-WORKMAN'S COMP? ☐ YES ☐ NO
15. DOES THE MEMBER HAVE OTHER INSURANCE? ENTER POLICY NUMBER:	
16. OTHER INSURANCE NAME:	17. PHONE NUMBER (xxx-xxx-xxxx):

ORDERING/REFERRING PROVIDER INFORMATION	
18. CONTACT PERSON IN REQUESTING PROVIDER'S OFFICE:	19. PHONE NUMBER (xxx-xxx-xxxx):
20. ORDERING/REFERRING PROVIDER NAME:	
21. PHONE NUMBER (xxx-xxx-xxxx):	22. FAX NUMBER (xxx-xxx-xxxx):
23. ORDERING/REFERRING PROVIDER ADDRESS:	24. NPI # (*REQUIRED*):

SERVICING PROVIDER INFORMATION	
25. FACILITY / SERVICING PROVIDER NAME:	26. CONTACT NAME:
27. PHONE NUMBER (xxx-xxx-xxxx):	28. FAX NUMBER (xxx-xxx-xxxx):
29. SERVICING PROVIDER ADDRESS:	30. NPI # (*REQUIRED*):

CLINICAL INFORMATION (ALL FIELDS REQUIRED)

31. SERVICE START DATE (MMDDYYYY):	SERVICE END DATE (MMDDYYYY):

32. ICD-10 / DSM-5 CODE(S) (*REQUIRED*):	33. ICD-10 / DSM-5 CODE(S) DESCRIPTION:

34. CPT / HCPCS CODE(S) (*REQUIRED*):	35. CPT / HCPCS CODE(S) DESCRIPTION:	36. QUANTITY / UNITS:

37. CLINICAL INDICATIONS / RATIONALE FOR REQUEST:

To prevent delay in processing your request for services, please attach clinical documentation / medical records to support your request. Please include the following: conservative treatment tried without success, applicable diagnostic testing with results, lab values and a medication list. Incomplete requests will delay the prior authorization process. .

AUTHORIZATION DOES NOT GUARANTEE PAYMENT. ALL AUTHORIZATIONS ARE SUBJECT TO MEMBER ELIGIBILITY ON THE DATE OF SERVCE. TO ENSURE PROPER PAYMENT FOR SERVICES RENDERED, PROVIDER/ FACILITY MUST VERIFY ELIGIBILITY ON THE DATE OF SERVICE.