# PHYSICAL HEALTH STANDARD PRIOR AUTHORIZATION REQUEST FORM

FAX TO: 1-844-797-7601 TELEPHONE: 1-855-232-3596

AETNA BETTER HEALTH OF NEW JERSEY
3 INDEPENDENCE WAY, SUITE 400
PRINCETON, NJ 08540
TELEPHONE NUMBER: 1-855-232-3596
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

****FORM MUST BE COMPLETED IN ITS ENTIRETY****

TYPE OF REQUEST: ☐ INPATIENT ☐ OUTPATIENT ☐ IN OFFICE ☐ IN HOME

☐ URGENT – WHEN A NON-URGENT PRIOR AUTHORIZATION REQUEST COULD SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF A MEMBER, THE MEMBER'S ABILITY TO ATTAIN, MAINTAIN, OR REGAIN MAXIMUM FUNCTION OR THAT A DELAY IN TREATMENT WOULD SUBJECT THE MEMBER TO SEVERE PAIN THAT COULD NOT BE ADEQUATELY MANAGED WITHOUT THE CARE/SERVICE REQUESTED. URGENT REQUESTS WILL BE PROCESSED WITHIN 72 HOURS

☐ NON-URGENT STANDARD – ROUTINE SERVICES PROCESSED WITHIN 14 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.