Aetna Better Health® of California
10260 Meanley Drive
San Diego, CA 92131
1-855-772-9076

Prior Authorization Form

Fax to**: 1-959-888-4048**; Telephone: **1-855-772-9076**

A determination will be communicated to the requesting provider.

- Incomplete requests will delay the prior authorization process.
- Visit ProPAT Search Tool to research whether a service requires prior authorization: https://www.aetnabetterhealth.com/california
- Please include pertinent clinical notes to expedite this request.

TYPE OF REQUEST

URGENT/EXPEDITED (to be used when non-urgent/standard prior authorization could seriously jeopardize the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or a delay in treatment would subject the member to severe pain that could not be adequately managed without the service requested)

NON-URGENT/STANDARD (for routine services – response within 7calendar days for Medicaid)

INPATIENT
OBSERVATION
OUTPATIENT
HOME HEALTH CARE
DME

PATIENT INFORMATION				
Patient Name: Last First MI				**Date of Birth:** / /
I.D.#:			**Gender:** M F	**EPSDT special service request?**
Other Insurance? YES NO	**Name of Carrier**	**Job Related?** YES NO	**MVA?** YES NO	**Is the member currently pregnant** YES NO

FROM- REQUESTING PROVIDER			
Requesting Provider (Please Print):			**Tax ID#:**
Contact Person in Requesting Provider's Office:	**Telephone:** ( ) -	**Fax:** ( ) -	**Medicaid Provider #:**
Clinical Contact Person: Phone: ( )		**Name of PCP:**	

TO- WHERE WILL PATIENT RECEIVE SERVICES?			
Physician/Provider/Facility Requested:	**Address:**	**Telephone:** ( ) -	**Fax:** ( ) -
Where services will be rendered? (Provide name of facility, if other than provider office or patient's home)			**Medicaid Provider #:**
Today's Date: / /		**Tentative Date of Service/Admission:** / /	
Were member school based services interrupted? YES NO		**Start Date:** / / **End Date:** / /	

CLINICAL INFORMATION	
ICD- 10 Codes: (required)	**ICD- 10 Description:**
CPT/HCPCS CODES: (required)	**CPT/HCPCS Description:**
Comments (list # Days/Visits/Units or if services are needed at discharge):	

CLINICAL INDICATIONS/RATIONALE FOR REQUEST:

***DME, Home Health, Therapies and Infusions must have Rx attached.**

To expedite a determination on your request for services, please attach clinical documentation/medical records to support your request. Please include the following: Conservative treatment tried and failed, applicable diagnostic testing with results and lab values and a medication list.

ATTESTATION:
I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Provider Signature:_____ Date:_____