





**BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST**

Aetna Better Health of Florida  
 261 N University Drive  
 Plantation, FL 33324  
 MMA Telephone: 800-441-5501  
 Comprehensive/LTC Telephone: 844-645-7371  
 Comprehensive/LTC Fax: 833-365-2474  
 Florida Health Kids (FHK) Telephone: 844-528-5815  
 Florida Health Kids (FHK) Fax: 833-365-2493  
 TTY: 771



Date of Request (MMDDYYYY):

**Include the following clinical documentation with the ECT/TMS Prior Authorization Request:**

- Recent comprehensive Psychiatric Evaluation
- History of Psychiatric Treatment to date (include all levels of care)
  - Include onset, course, and severity of illness
  - Response to treatment
  - Describe Patient's overall treatment compliance
- For prior ECT treatment, include dates, location, number of treatments, results and known contraindications to ECT
- Substance abuse history and current status
- Any labs/diagnostic tests available to the prescribing clinician

**SECTION 5 – PSYCHOLOGICAL / NEUROPSYCHOLOGICAL TESTING REQUEST**

Complete all fields in their entirety.

35. SERVICE TYPE REQUESTED Psychological <input type="checkbox"/> Neuropsychological <input type="checkbox"/>		36. PRIOR TESTING? (If yes, include date) Yes <input type="checkbox"/> DATE (MMDDYYYY): _____ No <input type="checkbox"/>	
37. CURRENT BH OUTPATIENT SERVICES? Yes <input type="checkbox"/> No <input type="checkbox"/>		38. PSYCHIATRIC DIAGNOSTIC EVALUATION? Yes <input type="checkbox"/> No <input type="checkbox"/>	

39. WHAT IS THE CLINICAL QUESTION TO BE ANSWERED BY TESTING?

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40. HOW WILL TESTING AFFECT MEMBER'S TREATMENT?

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41. DETAILED CLINICAL SUMMARY FROM TREATING PSYCHIATRIC PROVIDER FOR 6 MONTHS:

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**Include the following documentation with the Psychological/Neuropsychological Prior Authorization Request:**

- Detailed clinical summary (Physical & Behavioral Health)
- BHMP Evaluation & progress notes that detail assessment of clinical concern
- Any supporting rating scales
- Neurological assessment reviewed by BHMP (if request is for a Neuropsychological Evaluation)
- Any prior testing completed

**SECTION 6 – APPLIED BEHAVIORAL ANALYSIS (ABA)**

Complete all fields in their entirety.

42. REQUEST TYPE? Initial <input type="checkbox"/> Concurrent <input type="checkbox"/> If concurrent, how long has member been receiving services?	43. TREATMENT SETTING?
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44. CLINICAL SYMPTOMS OR SOCIAL BARRIERS?

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45. DISCHARGE PLAN (Anticipated date to transition to lower level of care)

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Date of Request (MMDDYYYY):

SECTION 7 – OUTPATIENT TREATMENT REQUEST (OTR) REQUEST				
Complete all fields in their entirety.				
46. REQUEST TYPE?		47. SERVICE TYPE?		
Initial <input type="checkbox"/>	Concurrent <input type="checkbox"/>	Substance Use Order <input type="checkbox"/>	Mental Health <input type="checkbox"/>	
48. Clinical Symptoms or Social Barriers?				
49. Discharge Plan (Anticipated date to transition to lower level of care):				
50. Substance Abuse and/or Mental Health History – History and Current Status:				
51. Criteria/Level of Care Utilized in Past 12 Months:				
Criteria/Level of Care	Name of Provider	Duration	Approximate Dates (MMDDYYYY-MMDDYYYY)	Outcome
52. OPTIONAL SPACE FOR ADDITIONAL DOCUMENTATION:				
<b>Include the following documentation with the ABA Request or OTR Prior Authorization Request:</b> <ul style="list-style-type: none"> <li>• Clinical data (Psycho/Social/Behavioral history, mental status, current specific maladaptive behaviors and/or skill deficits, co-occurring disorders, and medical condition(s))</li> <li>• Progress reducing target behaviors/skill deficits or lack of, and plan to address. For initial ABA requests, include progress or lack-of, with any previous treatment interventions</li> <li>• Compliance with treatment and treatment recommendations, include plan to address non-compliance</li> <li>• For ABA Requests, include treatment plan</li> </ul>				
SECTION 8 – ATTESTATION				
Complete all fields in their entirety.				
53. Printed Name of Provider/Clinician:			54. Date (MMDDYYYY):	
55. Signature of Provider/Clinician:				

**NOTE:** This form must be completed in its entirety in order to receive a determination. Incomplete forms may lead to delays in processing or lack of authorization.

**AUTHORIZATION DOES NOT GUARANTEE PAYMENT. ALL AUTHORIZATIONS ARE SUBJECT TO MEMBER ELIGIBILITY ON THE DATE OF SERVICE. TO ENSURE PROPER PAYMENT FOR SERVICES RENEDEDERED; P ROV IDER/FACILITY MUST VERIFY ELIGIBILITY ON THE DATE OF SERVICE.**