PHYSICAL HEALTH STANDARD PRIOR AUTHORIZATION REQUEST FORM

Comprehensive/LTC plan Fax: 844-404-5455;Comprehensive/LTC Telephone: 844-645-7371
Prior Auth MMA/FHK Fax: 860-607-8056; FHK Obstetrical (OB) Fax: 860-607-8726; Prior Auth MMA/FHK Telephone: 800-441-5501

Aetna Better Health of Florida
261 N University Drive
Plantation, FL 33324
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Comprehensive/LTC Fax: 844-404-5455
Prior Auth MMA/FHK Telephone: 800-441-5501
Prior Auth MMA/FHK Fax: 860-607-8056 FHK
Obstetrical (OB) Fax: 860-607-8726
TTY: 711

DATE OF REQUEST (MM/DDYYYY):

TYPE OF REQUEST: ☐ INPATIENT ☐ OUTPATIENT ☐ IN OFFICE

☐ 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 2 CALENDAR DAYS FOR MEDICAID AND COMPREHENSIVE/LTC MEMBERS; 72 hours FOR FLORIDA HEALTHY KIDS.

☐ NON-URGENT STANDARD – ROUTINE SERVICES PROCESSED WITHIN 7 CALENDAR DAYS FOR MEDICAID AND COMPREHENSIVE/LTC MEMBERS; 14 CALENDAR DAYS FOR FLORIDA HEALTHY KIDS.

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