

PHYSICAL HEALTH STANDARD PRIOR AUTHORIZATION REQUEST FORM



FAX TO 1-855-225-4102 TELEPHONE: 1-855-221-5656 TTY: 711

AETNA BETTER HEALTH OF KANSAS
 9401 Indian Creek Parkway, Suite 1300
 Overland Park, KS 66210

DATE OF REQUEST (ENTER MMDDYYYY)

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Form instructions: Please print with black ink only or type in all capital letters as shown in the example.

To select and fill an oval, double-click the oval, select the "Shape Fill" option, and select black as the fill-color to mark your selection.

TYPE OF REQUEST: INPATIENT OUTPATIENT OBSERVATION

URGENT - SIGNIFICANT IMPACT TO THE HEALTH OF A MEMBER. PROCESSED WITHIN (TAT 72 HOURS)

NON URGENT STANDARD – ROUTINE SERVICES PROCESSED WITHIN (TAT 14 DAYS)

VISIT OUR PROPAT SEARCH TOOL TO DETERMINE IF A SERVICE REQUIRES PA (insert web address here).
 A DETERMINATION WILL BE COMMUNICATED TO THE REQUESTING PROVIDER.

MEMBER INFORMATION

1. FIRST NAME

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2. LAST NAME

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4. DATE OF BIRTH (MMDDYYYY)

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5. MEDICAID ID #

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6. MEMBER'S TELEPHONE NUMBER (xxx-xxx-xxxx)

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7. MEMBER'S PCP

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8. PCP TELEPHONE NUMBER (xxx-xxx-xxxx)

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9. MEMBER'S GENDER:	MALE <input type="radio"/>	FEMALE <input type="radio"/>	10. IS THE MEMBER PREGNANT?	YES <input type="radio"/>	NO <input type="radio"/>
11. EPSDT SPECIAL SERVICE REQUEST?	YES <input type="radio"/>	NO <input type="radio"/>	12. MOTOR VEHICLE ACCIDENT?	YES <input type="radio"/>	NO <input type="radio"/>
13. COURT ORDERED?	YES <input type="radio"/>	NO <input type="radio"/>	14. JOB RELATED - WORKMAN'S COMP?	YES <input type="radio"/>	NO <input type="radio"/>

15. DOES THE MEMBER HAVE OTHER INSURANCE OR MEDICARE? YES NO

16. OTHER INSURANCE NAME:

17. OTHER INSURANCE CONTACT NUMBER:

REQUESTING PROVIDER INFORMATION

18. REQUESTING PROVIDER FIRST NAME

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19. REQUESTING PROVIDER LAST NAME

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20. CONTACT PERSON (Person to contact for additional questions.)

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21. TELEPHONE NUMBER (xxx-xxx-xxxx)

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22. FAX NUMBER (xxx-xxx-xxxx)

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24. NPI

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SERVICING PROVIDER INFORMATION

25. FACILITY OR SERVICING PROVIDER FIRST NAME

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26. SERVICING PROVIDER LAST NAME

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27. CONTACT PERSON (Person to contact for additional questions.)

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28. TELEPHONE NUMBER (xxx-xxx-xxxx)

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29. FAX NUMBER (xxx-xxx-xxxx)

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31. NPI

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CLINICAL INFORMATION (All fields required.)

32. DATES OF SERVICE: START DATE (MMDDYYYY)

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END DATE (MMDDYYYY)

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33. ICD-10 / DSM-5

34. ICD-10 / DSM-5 DESCRIPTION

35. CPT / HCPCS

36. CPT / HCPCS DESCRIPTION AND FREQUENCY

37. QUANTITY/UNITS

38. OTHER CLINICAL INFORMATION / COMMENTS:

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.

Authorization does not guarantee payment. All authorizations are subject to member eligibility on the date of service. To ensure proper payment for services rendered, provider/facility must verify eligibility on the date of service.