Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

Prior Authorization Form

Fax to 855-454-5579 Telephone: 888-725-4969

A determination will be communicated to the requesting provider.

- **Requests received after 6:00 p.m., Eastern Time, are processed the next business day.**
- Incomplete requests will delay the prior authorization process.
- Please include pertinent chart notes to expedite this request.

TYPE OF REQUEST

☐ **URGENT** (When a 2 business day non-urgent prior authorization 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.)

☐ **NON-URGENT** (for routine services – response within 2 business days)

☐ **ADDITIONAL CLINICAL**

☐ **INPATIENT**

☐ **OUTPATIENT** ☐ **DME**

☐ **HOME HEALTH CARE**

☐ **RX/BUY & BILL**

PATIENT INFORMATION

Patient Name: Last First MI				**Date of Birth:** / /
I.D.#:			**Gender**: M F	**EPSDT special service request?** YES NO
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:** ( ) -	**KY 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)			**KY 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) 1 2 3 4	**ICD-10 Description:**
CPT/HCPCS Codes: (required) 1 2 3 4	**CPT/HCPCS Description:**

Comments (**List # Days/Visits/Units or if services are needed at discharge**):

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

CLINICAL INDICATIONS/RATIONALE FOR REQUEST:
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.