

AETNA BETTER HEALTH® OF NEW JERSEY
Prior Authorization Request Form



Telephone: 1-855-232-3596

Fax: 1-844-797-7601

Date of Request: _____

For MLTSS Custodial Requests ONLY use Fax: 855-444-8694

**** Urgent requests are based on Medical Necessity ONLY, not for scheduling convenience ****

Please note: For non-urgent requests the turnaround time frame to review is **14 days**

URGENT REQUEST: _____

****FORM MUST BE COMPLETED IN ITS ENTIRETY****

SERVICE(S) REQUESTED: Please PRINT LEGIBLY or TYPE.

MEMBER INFORMATION

Name:	PCP Name (REQUIRED) :
DOB:	PCP Telephone:
Member ID#:	PCP Fax (REQUIRED) :
Gender (circle one): F M	National Provider ID (NPI):

PROVIDER INFORMATION (Ordering and/or Rendering Providers)

Referring Provider/Requesting Provider:	Place of Service or Facility Name:
Name:	Name:
Address:	Address:
Telephone:	Telephone:
Fax (REQUIRED) :	Fax (REQUIRED) :
National Provider ID # (NPI):	National Provider ID # (NPI):
Tax ID # (TIN):	Tax ID # (TIN):
Contact Person:	Contact Person:

REFERRAL/AUTHORIZATION INFORMATION

Diagnosis (List ICD-10 Codes):

PROCEDURE/SERVICES REQUESTED (list all CPT/HCPCS Codes)

CPT/HCPCS Codes:

Date(s) of service:	# of units/visits:
Type of Service (Circle one): Outpatient Office	
Post-Acute Inpatient Care (Circle one): Custodial Skilled Nursing Sub acute Acute Rehab	

REQUIRED DOCUMENTATION

Please attach supporting clinical information (e.g., Plan of Care, medical records, lab reports, PASSR, Letter of Medical Necessity, progress notes, etc.). In order for the member to receive requested services in a timely manner, be sure to provide **ALL** supporting documentation with the request.
If this is a DME request, use the DME Form from our website. For genetic testing, please describe testing and reason for request.

www.aetnabetterhealth.com/newjersey

Updated 12/18/2018