

BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST



Aetna Better Health of New Jersey
PO Box 818003
Cleveland, OH 44181-8003
Telephone Number: 1-855-232-3596
Fax Number: 1-844-404-3972
TTY: 711

Date of Request (MMDDYYYY):

Did you know that you can use our provider portal Availity® to submit prior authorization request, upload clinical documentation, check statuses, and make changes to existing requests? Register today at www.Availity.com

SERVICE TYPE: PSYCHOLOGICAL / NEUROPSYCHOLOGICAL APPLIED BEHAVIOR ANALYSIS (ABA)

ELECTROCONVULSIVE THERAPY (ECT) / TRANSCRANIAL MAGNETIC STIMULATION (TMS)

OUTPATIENT TREATMENT REQUEST (OTR)

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 24 hours.

NON - URGENT STANDARD – Routine services processed within 7 days.

Visit our ProPAT search tool to determine if a service requested requires PA <https://medicaidportal.aetna.com/propat/Default.aspx>. A determination will be communicated to the requesting provider.

COMPLETE SECTIONS 1-3 IN THEIR ENTIRETY.

SECTION 1 - MEMBER INFORMATION

1. FIRST NAME			2. M.I.	3. LAST NAME	
4. MEDICAID ID#			5. DATE OF BIRTH (MMDDYYYY)		6. MEMBER PHONE # (xxx-xxx-xxxx)
7. DOES THE MEMBER HAVE OTHER INSURANCE? (Include Policy Number Below)					

SECTION 2 ORDERING/REFERRING & SERVICING PROVIDER INFORMATION

8. ORDERING/REFERRING PROVIDER NAME			9. CONTACT PERSON (For questions)		
10. TELEPHONE # (xxx-xxx-xxxx)		11. FAX # (xxx-xxx-xxxx)		12. NPI	
13. SERVICING PROVIDER NAME / FACILITY / AGENCY			14. CONTACT PERSON (For questions)		
15. TELEPHONE # (xxx-xxx-xxxx)		16. FAX # (xxx-xxx-xxxx)		17. NPI	

SECTION 3 - DIAGNOSIS CODES AND SERVICE / HCPCS CODES

18. SERVICE START DATE (MMDDYYYY)		19. SERVICE END DATE (MMDDYYYY)	
20. ICD 10/ DSM 5 CODE(S)		21. CODE DESCRIPTION(S) Include description of the service when uncertain of a code.	

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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?

40. HOW WILL TESTING AFFECT MEMBER'S TREATMENT?

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

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?

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

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SECTION 7 – OUTPATIENT TREATMENT REQUEST (OTR) REQUEST				
Complete all fields in their entirety.				
46. REQUEST TYPE? Initial <input type="checkbox"/> Concurrent <input type="checkbox"/>		47. SERVICE TYPE? 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:				
Include the following documentation with the ABA Request or OTR Prior Authorization Request:				
<ul style="list-style-type: none"> • Clinical data (Psycho/Social/Behavioral history, mental status, current specific maladaptive behaviors and/or skill deficits, co-occurring disorders, and medical condition(s)) • 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 • Compliance with treatment and treatment recommendations, include plan to address non-compliance • For ABA Requests, include treatment plan 				
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 RENDERED; PROVIDER/FACILITY MUST VERIFY ELIGIBILITY ON THE DATE OF SERVICE.

www.aetnabetterhealth.com/newjersey
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