**AETNA BETTER HEALTH®**
**Prior Authorization Form**

## REQUEST FOR MEDICAL EQUIPMENT/MEDICAL SUPPLIES *Effective 5/23/2016*

**Phone:** 1-855-232-3596
**Fax:** 1-844-797-7601

Date of Request:______________________________

## MEMBER INFORMATION

Name ___________________________________________ID Number__________________________________

Date of Birth______________________________________ Gender (circle one) F M

Member Address _______________________________ __ Member Telephone_________________________

## REQUESTING PHYSICIAN OR PROVIDER INFORMATION

**Referring Provider/ Requesting Provider**

Name_____________________________________________________________________________________________

Address___________________________________________________ Specialty: ____________________________________

Telephone #______________________________________________ Fax #________________________________________

National Provider ID (NPI)___________________________________ TIN #: _______________________________________

## AUTHORIZATION INFORMATION

**Servicing Provider**

Name_____________________________________________________________________________________________

Address___________________________________________________ Specialty: ____________________________________

Telephone #______________________________________________ Fax#________________________________________

National Provider ID (NPI)___________________________________ TIN #:_______________________________________

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Diagnosis Related to Need (**ICD-10 Code**(s))_________________________________________________________________

Requested Equipment/ Medical Supplies (CPT Code(s) or HCPCS)___________________________________________________

Member WT:___________________________________ Member HT:______________________________

Rental or Purchase (Circle One) Length of Need_________________________

****Medical Necessity as determined by physician: (Please describe in space below)****

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***Please provide any additional documentation which may be related to the request which supports medical necessity***

**Physician Signature**________________________________________

**UPIN#**___________________________________________________ **Date**________________________________

**This form shall be considered a physician script, unless a standard script is necessary for the vendor**