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): Inpatient 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.***	