Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Prior Authorization Form

Fax to: **1-866-366-7008** Telephone: **1-844-835-4930**

A determination will be communicated to the requesting provider.

- **Please complete all fields - incomplete requests will delay the prior authorization process.**
- Please include pertinent chart notes to expedite this request.

TYPE OF REQUEST

❑ URGENT (When a 7 calendar 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 are/ service requested.)

❑ NON-URGENT (for routine services – response within 7 calendar days)

❑ **INPATIENT**
❑ **OUTPATIENT**
❑ **HOME HEALTH CARE**

Clear Form

PATIENT INFORMATION				
Patient Name: Last First MI				Date of Birth:
I.D. #:	Gender: ☐M ☐F	Did the member complete step therapy? ☐Y ☐N		EPSDT special service request?
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):		**NPI #:**	
Contact Person in Requesting Provider's Office:	Telephone:	Fax:	**Tax ID #:**
Clinical Contact Person:	Telephone:	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)			WV 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.