AETNA BETTER HEALTH®
Prior Authorization Form

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

Date of Request: _____

For urgent requests (required within 24 hours), call Aetna Better Health of New Jersey at 1-855-232-3596
Please note: For non-urgent requests the turnaround time frame to review is **14 days**

MEMBER INFORMATION

Name: _____ ID Number _____

Date of Birth: _____ Member's Telephone #:_____

Physician Name: _____ Other Insurance: _____

Gender (circle one): F M

REQUESTING PHYSICIAN OR PROVIDER INFORMATION

Referring Provider / Requesting Provider **Place of Service or Facility Name**

If you are an out of network Provider/ Facility, all information must be filled out in the entirely

Name: _____ Name: _____

Address: _____ Address: _____

Telephone #: _____ Telephone #: _____

Fax #: _____ Fax #: _____

Specialty: _____ Specialty: _____

National Provider ID (NPI): _____ National Provider ID (NPI): _____

Tax ID # (TIN):_____ Tax ID # (TIN):_____

Contact Person: _____ Contact Person: _____

REFERRAL / AUTHORIZATION INFORMATION

Problem / Diagnosis (**ICD-10 Code(s)**): _____
_____

Procedure / Test Requested (CPT Code(s)): _____
_____

Date of Appointment or Service: _____ Number of Visits Required: _____

Type of Procedure (Circle One): Inpatient Outpatient In Office

Post-Acute Inpatient Care (Circle One): Custodial Skilled Nursing Sub acute Acute Rehab

Other Clinical Information _____

Please attach supporting clinical information (e.g. Plan of Care, Medical Records, Lab Reports, Letter of Medical Necessity, Progress Notes, etc.) Clinical information is needed to review requests.