AETNA BETTER HEALTH® OF NEW YORK

Prior Authorization Form

MLTC Phone: 1-855-456-9126
MLTC Fax: 1-855-474-4978

Date of Request: ______________________

For urgent requests (required within 24 hours), call Aetna Better Health of New York at 1-855-456-9126

MEMBER INFORMATION

Name: ____ ID Number ______________________

Date of Birth: __________________________Physician Name: _______________________________________

Other Insurance: ____ Gender (circle one): **F** **M**

REQUESTING PHYSICIAN OR PROVIDER INFORMATION

Referring Provider / Requesting Provider	**Place of Service or Facility Name**
Name: _____________________________________	Name: ____
Address: __________________________________	Address: ______________________________________
Telephone #: _______________________________	Telephone #: ___________________________________
Fax #: ____________________________________	Fax #: ____
Specialty: __________________________________	Specialty: _____________________________________
National Provider Identification (NPI): ____________	National Provider Identification (NPI): ________________
Contact Person: _____________________________	Contact Person: ________________________________

REFERRAL / AUTHORIZATION INFORMATION

Problem / Diagnosis (ICD-9 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

Other Clinical Information - Include clinical notes, lab and X-ray reports, etc. (For procedures, please attach additional pages as necessary.): ____

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