Aetna Better Health® of Florida
1340 Concord Terrace
Sunrise, FL 33323

Prior Authorization Form

Fax to**: 1-860-607-8056**; OB Fax**: 1-860-607-8726** Telephone: **1-800-441-5501**

A determination will be communicated to the requesting provider.

- Incomplete requests will delay the prior authorization process.
- Visit ProPat Search Tool to research whether a service requires prior authorization: **http://aetnabetterhealth-florida.aetna.com**
- Please include pertinent clinical notes to expedite this request.

TYPE OF REQUEST

☐ **URGENT/EXPEDITED** (to be used when non-urgent/standard prior authorization could seriously jeopardize the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or a delay in treatment would subject the member to severe pain that could not be adequately managed without the service requested)

☐ **NON-URGENT/STANDARD** (for routine services – response within 7 calendar days for Medicaid; 14 calendar days for Florida Healthy Kids)

☐ **INPATIENT**
☐ **OBSERVATION**
☐ **OUTPATIENT**
☐ **HOME HEALTH CARE**
☐ **DME**

PATIENT INFORMATION

Patient Name: Last First MI				**Date of Birth:** / /
I.D.#:			**Gender:** M F	**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):			**Tax ID#:**
Contact Person in Requesting Provider's Office:	**Telephone:** ( ) -	**Fax:** ( ) -	**FL Medicaid Provider #:**
Clinical Contact Person: **Phone: ( ) -**		**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)			**FL 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)	**ICD- 10 Description:**
CPT/HCPCS CODES: (required)	**CPT/HCPCS Description:**
Comments (list # Days/Visits/Units or if services are needed at discharge):	

***DME, Home Health, 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.

ATTESTATION:
I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Provider Signature:_____ Date:_____

www.aetnabetterhealth.com/florida