AETNA BETTER HEALTH®
Prior authorization request form

SERVICE(S) REQUESTED: Please PRINT LEGIBLY or TYPE. **Please do not submit this form without supporting clinical.**

DME (check one if applicable): Rental ☐ Purchase ☐

MEMBER INFORMATION	
Name:	PCP Name:
DOB:	**Other insurance?:**
Member ID#:	Policy Number:
Gender (circle one): M or F	Policy Holder:
PROVIDER INFORMATION	
Ordering Physician/Nurse Practitioner:	**Servicing** Provider/Facility/Physician:
Name:	Name:
Address:	Address:
Tel:	Tel:
Fax:	Fax:
Contact Person:	Specialty:
NPI:	NPI:
REQUIRED CLINICAL INFORMATION	
Diagnoses (list **CODES** & description):	
1.	3.
2.	4.
Procedure/service requested **(list all CPT/HCPCS CODES & descriptions required)**:	
1.	4.
2.	5.
3.	6.
Date(s) of service:	# of units/visits:
For Home Health (shift care) ONLY:	
Number of hours per day:	Number of days per week:

(Telephone) 1-866-638-1232 (Fax) 1-877-363-8120

REQUIRED DOCUMENTATION
Please attach supporting clinical information (e.g., Plan of Care, medical records, lab reports, letter of medical necessity, progress notes, etc). **Requests received without supporting clinical notes and required codes <u>WILL NOT</u> be reviewed.** **IF THIS IS A REQUEST FOR THERAPY, PLEASE USE A SEPARATE FORM FOR EACH SERVICE!** <u>(e.g., one form for PT with all codes and clinical, one form for OT with all codes and clinical etc.)</u>

www.aetnabetterhealth.com/pennsylvania

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