Aetna Better Health® of Florida
261 N University Drive
Plantation, FL 33324

Prior Authorization Form

MMA/FHK/Comprehensive/LTC

Prior Auth MMA/FHK Fax: **1-860-607-8056**; **Obstetrical** (OB) Fax: **1-860-607-8726** Prior Auth Telephone: **1-800-441-5501**
Comprehensive/Long Term Care Requests Fax: **1-844-404-5455 Comprehensive/Long Term Care** Telephone**: 1-844-645-7371**

A determination will be communicated to the requesting provider

- Visit ProPat Search Tool to research whether a service requires prior authorization: http://www.aetnamedicaidportal.com/propat/Default.aspx
- An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services rendered must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.
- **All Inpatient and Observation Hospital admissions for MMA/FHK/Comprehensive members must be called in to the MMA/FHK Prior Authorization Department: Phone number 1-800-441-5501**

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—response within 2 calendar days for Medicaid and Comprehensive/LTC members; 3 calendar days for Florida Healthy Kids)

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

☐ **OUTPATIENT**

☐ **HOME HEALTH CARE**

☐ **DME/Supplies**

PATIENT INFORMATION

Asterisk (*) Indicates REQUIRED fields. Incomplete requests will delay the authorization process.

Please include pertinent clinical notes to expedite this request.

*** Membership Type:** ☐ **MMA** ☐ **FHK** ☐ **Comprehensive** ☐ **LTC**

*Patient Name: Last	First	MI	*Member ID/Medicaid ID:	*Date of Birth: / /

*PCP Name:	*Phone: ( )	*Fax: ( )	*PCP Contact Name:

REQUESTING PROVIDER INFORMATION

*Requesting Provider Name:	*Requesting NPI:	*Requesting TIN:

*Requesting Contact Name:	*Phone: ( )	*Fax: ( )

SERVICING PROVIDER INFORMATION

☐ **Servicing Provider same as Requesting Provider** (Please select if the Provider's information above is the same)

*Servicing Provider Name:	*FL Medicaid Provider#:	*Servicing NPI:	*Servicing TIN:

*Servicing Provider Contact Name:	*Phone: ( )	*Fax: ( )

*Servicing Facility Name:	*FL Medicaid Provider#:	*Facility NPI:	*Facility TIN:

*Servicing Facility Contact Name:	*Phone: ( )	*Fax: ( )

AUTHORIZATION REQUEST

*Start Date:	*End Date:	*Total Units/Visits (Total units should be based on CPT/HCPCS description of units):

*Have services already been rendered? ☐ Yes ☐ No

*Procedure Codes:	*ICD- 10 Codes:

Comments:

CLINICAL INDICATIONS/RATIONALE FOR REQUEST: *DME, Home Health, Therapies and Infusions must have Rx attached.
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:** _____