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PHYSICAL HEALTH STANDARD PRIOR AUTHORIZATION REQUEST

FAX TO: 833-923-0831 TELEPHONE: 844-365-4385

Aetna Better Health of Oklahoma
777 NW 63rd Street, Suite 100
Oklahoma City, OK 73116

Telephone Number: 844-365-4385
Fax Number: 833-923-0831
TTY: 844-365-4385, 711

Date of Request

Did you know that you can use our provider portal Availity® to submit prior authorization request, upload clinical documentation, check statuses, and make changes to existing requests? Register today at www.Availity.com

TYPE OF REQUEST:

☐ INPATIENT ☐ OUTPATIENT ☐ IN OFFICE

☐ URGENT – When a non-urgent prior authorization request could seriously jeopardize the life or health of a member. The member's ability to attain, maintain, or regain maximum function or that a delay in treatment would subject the member to severe pain that could not be adequately managed without the care/service requested. Urgent requests will be processed within 24 hours.

☐ NON - URGENT STANDARD – Routine services processed within 72 hours.

Visit our ProPAT search tool to determine if a service requested requires PA https://medicaidportal.aetna.com/propat/Default.aspx. A determination will be communicated to the requesting provider.

SECTION 1 – MEMBER INFORMATION		
1. LAST NAME:	**2. FIRST NAME:**	**3. MI:**
4. MEMBER AETNA ID #: (*REQUIRED*)	**5. DATE OF BIRTH:** (MMDDYYYY) (*REQUIRED*)	**6. MEMBER PHONE #** (XXX-XXX-XXXX)

7. PCP PHONE NUMBER: (xxx-xxx-xxxx)	**8. PCP FAX NUMBER:** (xxx-xxx-xxxx)
9. GENDER	**10. IS THE MEMBER PREGNANT?**
MALE ☐ FEMALE ☐ OTHER ☐	Yes ☐ No ☐
11. EPSDT SPECIAL SERVICE REQUEST?	**12. MOTOR VEHICLE ACCIDENT?**
Yes ☐ No ☐	Yes ☐ No ☐
13. COURT ORDERED?	**14. JOB RELATED-WORKMAN'S COMP?**
Yes ☐ No ☐	Yes ☐ No ☐

15. DOES THE MEMBER HAVE OTHER INSURANCE? ENTER POLICY NUMBER:	
16. OTHER INSURANCE NAME:	**17. PHONE NUMBER:** (xxx-xxx-xxxx)

ORDERING / REFERRING PROVIDER INFORMATION	
18. CONTACT PERSON IN REQUESTING PROVIDER'S OFFICE:	**19. PHONE NUMBER:** (xxx-xxx-xxxx)
20. ORDERING/REFERRING PROVIDER NAME:	
21. PHONE NUMBER: (xxx-xxx-xxxx)	**22. FAX NUMBER:** (xxx-xxx-xxxx)
23. ORDERING/REFERRING PROVIDER ADDRESS:	**24. NPI #** (*REQUIRED*)

SERVICING PROVIDER INFORMATION	
25. FACILITY / SERVICING PROVIDER NAME:	**26. CONTACT NAME:**
27. PHONE NUMBER: (xxx-xxx-xxxx)	**28. FAX NUMBER:** (xxx-xxx-xxxx)
29. SERVICING PROVIDER ADDRESS:	**30. NPI # (*REQUIRED*):**

SERVICING PROVIDER INFORMATION	
25. FACILITY / SERVICING PROVIDER NAME:	**26. CONTACT NAME:**
27. PHONE NUMBER: (xxx-xxx-xxxx)	**28. FAX NUMBER:** (xxx-xxx-xxxx)
29. SERVICING PROVIDER ADDRESS:	**30. NPI # (*REQUIRED*):**

CLINICAL INFORMATION (ALL FIELDS REQUIRED)	
31. SERVICE START DATE (MMDDYYYY):	**SERVICE END DATE (MMDDYYYY):**
32. ICD-10 / DSM-5 CODE(S): (*REQUIRED*)	**33. ICD-10 / DSM-5 CODE(S) DESCRIPTION:**

34. CPT/HCPCS CODE(S): (*REQUIRED*)	**35. CPT/HCPCS CODE(S) DESCRIPTION**	**36. QUANTITY/UNITS:**

37. CLINICAL INDICATIONS/RATIONALE FOR REQUEST:

To prevent delay in processing your request for services, please attach clinical documentation / medical records to support your request. Please include the following: conservative treatment tried without success, applicable diagnostic testing with results, lab values and a medication list. Incomplete requests will delay the prior authorization process.

AUTHORIZATION DOES NOT GUARANTEE PAYMENT. ALL AUTHORIZATIONS ARE SUBJECT TO MEMBER ELIGIBILITY ON THE DATE OF SERVCE. TO ENSURE PROPER PAYMENT FOR SERVICES RENDERED, PROVIDER/ FACILITY MUST VERIFY ELIGIBILITY ON THE DATE OF SERVICE.