Aetna Better Health® of California
10260 Meanley Drive
San Diego, CA 92131
1-855-772-9076

Adult & Pediatric Palliative Care Provider Referral Form

Fax to**: 1-959-888-4049**; Telephone: **1-855-772-9076**

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: https://www.aetnabetterhealth.com/california
- 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 seven calendar days for Medicaid)

PATIENT INFORMATION			
Patient Name: Last First MI			**Date of Birth:** / /
I.D.#:		**Gender:** M F	
Other Insurance? YES NO	**Name of Carrier:**		
FROM- REQUESTING PROVIDER			
Requesting Provider (Please Print):			**Tax ID#:**
Contact Person in Requesting Provider's Office:	**Telephone:** ( ) -	**Fax:** ( ) -	**Medicaid Provider #:**
Clinical Contact Person: Phone: ( )	**Name of PCP:**		
TO- WHERE WILL PATIENT RECEIVE SERVICES?			
☐ **Hospital** ☐ **Community- Based**	☐**Facility** ☐**Home**	**Facility/Home Address**	**Telephone:** ( ) -	**Fax:** ( ) -
Palliative Care Provider:			**Medicaid Provider #:**
Today's Date: / /	**Tentative Date of Service/Admission:** / /		
CLINICAL INFORMATION			
Qualifying Diagnosis (ICD-10)	**ICD- 10 Description:**		
Comments (list # Days/Visits/Units or if services are needed at discharge):			

CLINICAL INDICATIONS/RATIONALE FOR REQUEST:

To expedite a determination on your request for services, please attach:

Referring Provider:

- Clinical documentation/medical records to support your qualifying diagnosis

Palliative Care Partner:

- Initial Assessment from Palliative Care Partner will be used as physician certification and will be needed for authorization purposes into the program **(response required within seven calendar days)**

ATTESTATION:

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

Provider Signature:_____ Date:_____

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CA-20-11-25