Aetna Better Health® of California
10260 Meanley Drive
San Diego, CA. 92131

Prior authorization Form-San Diego

Fax to 1-844-584-4450 Telephone: 1-855-772-9076

A determination will be communicated to the requesting provider.

- **Requests received after 5:00p.m., Pacific Time, are processed the next business day.**
- Incomplete requests will delay the prior authorization process.
- Please include pertinent chart notes to expedite this request.

TYPE OF REQUEST

☐ **URGENT** (When a 5-business day non-urgent prior authorization 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 sever pain that could not be adequately managed without the are/service requested.)

☐ **NON-URGENT** (for routine services – response within 5 business days of receipt of all information reasonably necessary to render a decision but no longer than 14 calendar days)

☐ **INPATIENT**

☐ **OUTPATIENT**

☐ **HOME HEALTH CARE**

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:** ( ) -	**CA Medicaid Provider #:**
Clinical Contact Person: **Phone: ( ) -**		**Name of PCP:**	

TO- WHERE WILL PATIENT RECEIVE SERVIES?

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)			**CA 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) 1 2 3 4	**ICD-10 Description:**
CPT/HCPCS CODES: (required) 1 2 3 4	**CPT/HCPCS Description:**
Comments (list # Days/Visits/Units or if services are needed at discharge): ***DME, 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.