Aetna Better Health® of Kentucky

9900 Corporate Campus Drive, Suite 1000 Louisville, KY 40223



Provider fax:

AETNA BETTER HEALTH® OF KENTUCKY

Provider name (direct contact, please print)

Outpatient Treatment Request (OTR)

Fax as a single document to AETNA BETTER HEALTH OF KENTUCKY 1-855-301-1564 or SKY 1-833-689-1424

Provider phone:

Member name (please print)			Medicaid ID#		С	Date of birth					
Duariday NDL			710				AX ID	/			
Provider NPI:			ZIP			'	AX ID				
(required) Diagnosis ICD-10:			Comparid ICD 10 modical diagnosis:								
Diagnosis ICD-10:			Comorbid ICD-10 medical diagnosis:								
SED ? □ SMI? □											
How long has the member been receiving services?:		Medications:									
Frequency of services?:			Compliant?								
Are any supporting documents included with this request? Yes No											
To determine if a service requires prior authorization, please visit: http://www.aetnamedicaidportal.com/propat/Default.aspx											
CPT/HCPCS codes requested											
Code	Units Requested	Modifier	Request start date: End date:								
	•										
			Please note: Requests MUST be received within (2) buisness								
			days of the requested start date. The maximum timeframe that may be requested is (3) months.								
			_ that h	nay be ree	uestet	. 13 (3) 1110111					
Functional impairment rating scale (Check the box to indicate current level of impairment in each domain)											
			Current level of impairment								
Affective: Depress	ion, mania, mood insta	bility, inappro	priate	None		Modera	te	Severe			
Anxiety: Panic, wo	rry, easily startled, flas	shbacks, nightr	mares								
ADHD symptoms: Hyperactivity, impulsivity, poor insight,											
poor judgment											
Obsessions & Compulsions: Rituals, fear of contamination,											
excessive need for orderliness, hair pulling											
Reality Construction & Thought processes: Delusions,											
hallucinations, disorganized or racing thoughts, dissociative											
states, paranoia			tive								
• • • • • • • • • • • • • • • • • • • •	organized or racing tho	ughts, dissocia	tive								
-	organized or racing tho	ughts, dissocia	tive								
dementia and mer	organized or racing tho ve impairments due to ntal retardation	ughts, dissocia brain trauma,									
dementia and mer	organized or racing tho	ughts, dissocia brain trauma, ships, isolatior	٦,								

	None		Moderate		Severe				
Substance Abuse: Problematic use of drugs or alcohol									
Harm to Self or Other: Suicidal ideation, intentionally self-									
injurious behavior, suicide planning, danger to others									
Appetite/Eating: Disturbances in appetite, anorexia/bulimia									
Sleep: Disturbances in sleep patterns, excessive sleep									
Other medical conditions: Presence of medical conditions									
which have significant impact on patient functioning and/or									
quality of life									
Check if member has been previously hospitalized: Date: (if known) Check if the member is pregnant:									
The following information MUST be provided in order to mak	e a dete	rmina	ition.						
Clinical Data: (psycho/social/behavioral history, mental statu specific functional impairments, co-occuring disorders and mental statu specific functional impairments are specific functional impairments.	-			h sym	ptomology,				
Progress: (or lack of, and plan to address)									
Compliance with treatment and treatment recommendations: (include plan to address noncompliance)									
Discharge planning: (when is the member expected to transit this transition?)	ion to a	lower	level of care	? Wha	at is impeding				
Provider Signature: Dat	te:								