



PHYSICAL HEALTH STANDARD PRIOR AUTHORIZATION REQUEST

FORM FAX TO: 1-866-366-7008 TELEPHONE: 1-844-835-4930

AETNA BETTER HEALTH OF WEST VIRGINIA
500 VIRGINIA STREET EAST, SUITE 400
CHARLESTON, WV 25301
TELEPHONE NUMBER: 1-844-835-4930
TTY: 711

DATE OF REQUEST (MM/DD/YYYY):

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 2 BUSINESS DAYS.

NON-URGENT STANDARD – ROUTINE SERVICES PROCESSED WITHIN 7 CALENDAR DAYS.

VISIT OUR PROPAT SEARCH TOOL TO DETERMINE IF A SERVICE REQUIRES PA https://medicaidportal.aetna.com/propat/Default.aspx. A DETERMINATION WILL BE COMMUNICATED TO THE REQUESTING PROVIDER.

MEMBER INFORMATION
1. LAST NAME: 2. FIRST NAME: 3. MI:
4. MEMBER AETNA ID # (*REQUIRED*): 5. DATE OF BIRTH (MMDDYYYY) (*REQUIRED*): 6. MEMBER'S PCP:
7. PCP PHONE NUMBER (xxx-xxx-xxxx): 8. PCP FAX NUMBER (xxx-xxx-xxxx):
9. GENDER: MALE FEMALE OTHER 10. IS THE MEMBER PREGNANT? YES NO
11. EPSDT SPECIAL SERVICE REQUEST? YES NO 12. MOTOR VEHICLE ACCIDENT? YES NO
13. COURT ORDERED? YES NO 14. JOB RELATED-WORKMAN'S COMP? 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*):

