Behavioral Health Acute Request

FAX TO: 844-528-3453 | TELEPHONE: 866-329-4701

Aetna Better Health of Illinois
PO Box 818031, MC F661
Cleveland, OH 44181-8031

Telephone Number:
866-329-4701 Fax Number:
844-528-3453 TTY: 771

Date of request

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

☐ 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.

☐ NON - URGENT STANDARD – Routine services.

SERVICE TYPE:

☐ **ACUTE MENTAL HEALTH INPATIENT**

☐ **INPATIENT SUBSTANCE USE DETOX LEVEL** ☐ **3.7** ☐ **4.0**

☐ **RESIDENTIAL SUBSTANCE USE LEVEL 3.7**

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.

COMPLETE SECTIONS 1-4 IN THEIR ENTIRETY

NOTE: SECTION 7 "ATTESTATION" MUST BE COMPLETED FOR ALL REQUESTS

SECTION 1 – MEMBER INFORMATION		
FIRST NAME:	**MI:**	**LAST NAME:**
MEMBER AETNA ID #: (*REQUIRED*)	**DATE OF BIRTH:** (MMDDYYYY) (*REQUIRED*)	
DOES THE MEMBER HAVE OTHER INSURANCE? (Include Policy Number Below)		

SECTION 2 – ORDERING/REFERRING & SERVICING PROVIDER INFORMATION		
ORDERING/REFERRING PROVIDER NAME	**CONTACT PERSON** (For questions)	
TELEPHONE # (xxx-xxx-xxxx)	**FAX #** (xxx-xxx-xxxx)	**NPI**
SERVICING PROVIDER NAME / FACILITY / AGENCY	**CONTACT PERSON** (For questions)	
TELEPHONE # (xxx-xxx-xxxx)	**FAX #** (xxx-xxx-xxxx)	**NPI**

SECTION 3 – DIAGNOSIS CODES AND SERVICE / HCPCS CODES	
SERVICE START/ADMISSION DATE (MMDDYYYY)	
ICD 10 / DSM 5 CODE(S)	**CODE DESCRIPTION(S):** Include description of the service when uncertain of a code

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 including any supporting clinical documentation with discharge planning information (ex:estimated discharge date/barriers to discharge etc). Incomplete requests will delay the prior authorization process.

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