



AETNA BETTER HEALTH®
Prior Authorization Form

Phone: 1-855-232-3596

Fax: 1-844-797-7601

Date of Request: _____

For urgent requests (required within 24 hours), call Aetna Better Health of New Jersey at 1-855-232-3596

MEMBER INFORMATION

Name: _____ ID Number _____

Date of Birth: _____ Physician Name: _____

Other Insurance: _____ Gender (circle one): **F** **M**

REQUESTING PHYSICIAN OR PROVIDER INFORMATION

Referring Provider / Requesting Provider

Place of Service or Facility Name

Name: _____ Name: _____

Address: _____ Address: _____

Telephone #: _____ Telephone #: _____

Fax #: _____ Fax #: _____

Specialty: _____ Specialty: _____

National Provider Identification (NPI): _____ National Provider Identification (NPI): _____

Contact Person: _____ Contact Person: _____

REFERRAL / AUTHORIZATION INFORMATION

Problem / Diagnosis (ICD-9 Code(s)): _____

Procedure / Test Requested (CPT Code(s)): _____

Date of Appointment or Service: _____ **Number of Visits Required:** _____

Type of Procedure (circle one): Inpatient Outpatient In Office

Other Clinical Information - Include clinical notes, lab and X-ray reports, etc. (For procedures, please attach additional pages as necessary.): _____

www.aetnabetterhealth.com/newjersey