Aetna Better Health® of California
10260 Meanley Drive
San Diego, CA 92131
1-855-772-9076

Prior Authorization Form

Fax to**: 1-959-888-4048**; Telephone: **1-855-772-9076**

A determination will be communicated to the requesting provider.

- Incomplete requests will delay the prior authorization process.
- Visit ProPAT Search Tool to research whether a service requires prior authorization: https://www.aetnabetterhealth.com/california
- Please include pertinent clinical notes to expedite this request.

Routine

TYPE OF REQUEST

URGENT/EXPEDITED (to be used when non-urgent/standard prior authorization could seriously jeopardize the life or health of a member, the member's ability to attain, maintain, or regain maximum function, or a delay in treatment would subject the member to severe pain that could not be adequately managed without the service requested)

NON-URGENT/STANDARD (for routine services – response within 7calendar days for Medicaid)

INPATIENT
OBSERVATION
OUTPATIENT
HOME HEALTH CARE
DME

Michael Johnson 06/25/1967

659843217

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:** ( ) -	**Medicaid Provider #:**
Clinical Contact Person: Phone: ( ) Dr. Lina Nguyen, MD		**Name of PCP:** 6543219870	

TO- WHERE WILL PATIENT RECEIVE SERVICES?

Physician/Provider/Facility Requested: Aetna POS	**Address:**	**Telephone:** ( ) -	**Fax:** ( ) -
Where services will be rendered? (Provide name of facility, if other than provider office or patient's home) Sunrise Cardiology Associates			**Medicaid Provider #:** AE7645392I0
Today's Date: / /	225 Broadway, Suite 101, Seattle, WA	**Tentative Date of Service/Admission:** / /	
Were member school based services interrupted? YES NO		**Start Date:** / / **End Date:** / /	

CLINICAL INFORMATION

ICD- 10 Codes: (required) EKG Stress Test	**ICD- 10 Description:**
CPT/HCPCS CODES: (required) I20.9 - Angina Pectoris	**CPT/HCPCS Description:**
93015 - Cardiovascular Stress Test	
Comments (list # Days/Visits/Units or if services are needed at discharge):	

CLINICAL INDICATIONS/RATIONALE FOR REQUEST:

***DME, Home Health, Therapies and Infusions must have Rx attached.**

11/10/2023

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.

ATTESTATION: Doctor's Referral, Lab Results

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Provider Signature:_____ Date:_____