Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

AETNA BETTER HEALTH® OF KENTUCKY
Outpatient Treatment Request (OTR)
Fax as a single document to AETNA BETTER HEALTH OF KENTUCKY **1-855-301-1564**

Provider name (direct contact, please print)	**Provider phone:**	**Provider fax:**
Member name (please print)	**Medicaid ID#**	**Date of birth** / /
Provider NPI: **(required)**	**ZIP**	**TAX ID**
Diagnosis ICD-10: **SED ?** ☐ **SMI?** ☐	**Comorbid ICD-10 medical diagnosis:**	
How long has the member been receiving services?: **Frequency of services?:**	**Medications:** **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.

Functional impairment rating scale (Check the box to indicate current level of impairment in each domain)					
	Current level of impairment				
Affective: Depression, mania, mood instability, inappropriate	None ☐	☐	Moderate ☐	☐	Severe ☐
Anxiety: Panic, worry, easily startled, flashbacks, nightmares	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐
Cognitive: Cognitive impairments due to brain trauma, dementia and mental retardation	☐	☐	☐	☐	☐
Social: Difficulty forming positive relationships, isolation, anger/aggression, interpersonal problems at work/school	☐	☐	☐	☐	☐

	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 make a determination.

Clinical Data: (psycho/social/behavioral history, mental status, current behavioral health symptomology, specific functional impairments, co-occuring disorders and medical conditions, etc.)

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Progress: (or lack of, and plan to address)

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Compliance with treatment and treatment recommendations: (include plan to address noncompliance)

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Discharge planning: (when is the member expected to transition to a lower level of care? What is impeding this transition?)

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Provider Signature:______________________ **Date:______________**