

Aetna Better Health® of Texas

P O Box 569150

Dallas, TX 75356-9150

1.800.245.5380 (Tarrant CHIP) | 1.866.818.0959 (Bexar CHIP)

1.800.306.8612 (Tarrant Medicaid) | 1.800.248.7767 (Bexar Medicaid)

1-844-STRKIDS (787-5437) & TTY: 711



AETNA BETTER HEALTH® OF TEXAS

<MMDDYYYY>

<Member Name>

<Member Address>

<City, State, Zip Code>

Subject: Prior Authorization Request for Aetna Better Health Medicaid Member

Member Name:

Member ID:

Requesting Provider:

Date Request Received:

Requested Service(s): <type and amount>

Requested Date(s) of Service:

Authorization Number:

Dear Aetna Better Health Medicaid Member:

We would like to inform you of (member or an individual acting on behalf of the member, and the member's provider of record, including the health care provider who rendered the service) our decision about this request. A doctor looked at all of the records that were sent to us. We also tried to talk to your doctor about the request. Any new information given to us was considered. The doctor who made the decision is Board Certified in <insert specialty>.

Decision

The request for < requested service> is <choose one of the following: denied or partially denied>. < Use this sentence if this is a partial approval: The services that have been partially approved are: 1) enter specific services and certification>.

The facts do not show that the services are needed to treat your condition. The reason for this decision is:

<Enter Clinical Rationale including the principle reason. >.

Guideline(s) used in making this decision

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We use national and/or plan guidelines to help us make our decisions. In this case the criteria we used [<insert criteria>](#) which states:

You can ask for a free copy of the guideline(s). Call the Aetna Better Health Member Advocate at the number below and we will send you a copy within ten (10) working days.

The doctor who made the request has been told about this decision. The date the decision will take effect is [<mmddyyyy>](#). If are asking to continue care we have approved before, this is the last day the care will be approved. *Use this sentence if applicable* [< Lack of supporting documentation from <insert provider name and service> has been requested.>](#)

Legal Basis for this decision

Reductions and denials based on medical necessity are authorized by Social Security Act §1902(a)(30). Denials based on non-covered services and out-of network provider, are authorized by the Texas Medicaid State Plan, adopted in compliance with Social Security Act, Title XIX and the CMS approved §1915(b) Waiver to the requirements of the Social Security Act, under which Aetna Better Health contracts with the Texas Health and Human Services Commission to provide Medicaid covered services to Medicaid eligible individuals. This notice is required by Social Security Act §§1902(a)(3) and 1932(b)(4).

You may also refer to the [<20XX>](#) Texas Medicaid Provider Procedures Manual, Section [<xxx>](#).

This decision does not affect any other benefits you can get. (Include alternatives in this section if appropriate – “Although we cannot approve xxx, you may want to consider xxx)

Personal Care Services

[<If the determination is that the requested services are not nursing services use this language>](#)

The medical information received may support authorization of Personal Care Services.

Personal Care Services are support services provided to Medicaid beneficiaries under 21 years of age who require assistance with activities of daily living and health related functions because of a physical, cognitive or behavioral limitation related to their disability or chronic health condition. For more information and how to obtain personal care services for a Medicaid beneficiary under 21 years of age, you should contact Aetna Better Health or the PCS Client Line at 1-888-276-0702.>

Home Health Skilled Nursing Services

[<If the determination is that request does not support Private Duty Nursing use this language>](#)

The medical information received may support authorization of Home Health Skilled Nursing services. Home Health Skilled Nursing services are nursing services provided on a per-visit basis. Home Health Skilled Nursing services may be provided to meet chronic needs, acute care

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needs or on an ongoing basis to meet chronic needs. For more information and to find out how to obtain Home Health Skilled Nursing services, you should contact Aetna Better Health.>

A copy of this letter has been sent to your primary care provider and others, if needed. You should call your primary care provider to help with any future requests for health care services.

If you need help getting care (doctor visits, supplies or other services), information about care management services or Case Management for Children and Pregnant Women, please call us and ask to speak to the Aetna Better Health Member Advocate.

Sincerely,

<Nurse Initials>

Aetna Better Health

Attachments: Aetna Process for Filing a Complaint and Appeal of an Adverse Determination
and Requesting a Fair Hearing for Aetna Better Health Medicaid Members
Process for Filing for a Fair Hearing Request Form
Listing of Legal Service Providers

Copies to: <PCP>
<Other providers>