**SUBMIT TO**
**Utilization Management Department**
PHONE 1.844.265.1278 FAX 1.877.941.0481

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## APPLIED BEHAVIORAL ANALYSIS PRIOR AUTHORIZATION REQUEST FORM

**Please print clearly and fill out entire form even if the information is documented in attachments. Incomplete or illegible forms will be returned.**

### MEMBER INFORMATION

Member Name: _____

Medicaid ID#: _____

Date of Birth: _____ Age: _____

Phone Number: _____ Gender: ☐ M ☐ F

### BILLING PROVIDER:

Provider Name: _____

Tax ID#: _____

Provider NPI#: _____

Provider Address: _____

Contact Name: _____

Phone Number: _____

Fax Number: _____

☐ HSSP/ Psychiatrist ☐ Physician

### SUPERVISING PROVIDER:

Provider Name: _____

Group Facility Name: _____

Tax Id#: _____

Provider NPI#: _____

Provider Address: _____

Contact Name: _____

Phone Number: _____

Fax Number: _____

### DIAGNOSTIC AND TREATMENT INFORMATION

Primary Diagnosis (Required): _____

Secondary: _____

Prior Treatment relative to Diagnosis: _____

_____

_____

Diagnosis Date: _____

Standardized Tools used for Diagnosis: _____

_____

_____

Is the member in school? ☐ Yes ☐ No

Does the member have an IEP or 541 plan? ☐ Yes ☐ No

Does the member receive early intervention services? ☐ Yes ☐ No

Please describe other services received in addition to the ABA requested to including but not limited to: PT, OT, ST or mental health services: _____

_____

_____

Is this an initial request for authorization? ☐ Yes ☐ No

Date ABA Treatment Initiated: _____

Date of most recent reassessment: _____

### REQUESTED AUTHORIZATION (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATED MODIFER, IF APPLICABLE)

**All services require prior authoirzation, please indicated which codes below you are requesting**

| Code | Description | Units per Week/Month 1 unit = 15 min. | Total Unit |
|---|---|---|---|
| ☐ 0373T | Adaptive Behavior Treatment with Protocol Modification – two or more technicians | | |
| ☐ 97151 | Behavior Identification Assessment | | |
| ☐ 97152 | Behavior Identification Supporting Assessment - by technician | | |
| ☐ 97153 | Adaptive Behavior Treatment - by technician | | |
| ☐ 97154 | Group Adaptive Behavior Treatment – by technician | | |
| ☐ 97155 | Adaptive Behavior Treatment with Protocol Modification – by technician | | |
| ☐ 97156 | Family Adaptive Behavior Treatment Guidance - by technician | | |

| Code | Description | Units per Week/Month 1 unit = 15 min. | Total Unit |
|---|---|---|---|
| ☐ 97157 | Family Adaptive Behavior Treatment Guidance – two or more technicians | | |
| ☐ 97158 | Group Adaptive Behavior Treatment – two or more technicians | | |

HSPP or Physician Signature: _____ Date: _____

By signing the above, I attest that I am actively participating in the treatment plan and coordinating services for the member.

Rendering Provider Signature: _____ Date: _____

By signing the above, I attest that all professionals and paraprofessinals rendering service under the proposed treatment plan have the appropriate training and education required to render services.

## ADDITIONAL INFORMATION REQUIREMENTS

Please submit the information noted below with all treatment requests. If documentation is not received, the requests will be reviewed based on the information available at the time of the review.

- For initial assessment please submit: Comprehensive diagnostic information including standardized measures and referral from diagnosing provider for ABA services to include estimated duration of care.

**For initial treatment plan please submit:**

- Objective testing showing significant behavioral deficit.
- Description of coordination of services with other providers (school, PT, OT,ST).
- Proposed treatment schedule including the provider type who will render services.
- Proposed functional, and measureable treatment goals with expected timeframes which target identified behavior deficits.
- Proposed plan for parent involvement and training and parent's goals for outcomes.
- Any medical conditions that will impact outcomes of treatment.
- Copy of IEP or IFSP if applicable.

**For subsequent treatment requests please submit:**

- Objective measures of current status.
- Objective measures of clinically significant progress towards each stated treatment goal.
- Updated plan for treatment including updated goals and timeline for achievement.
- Any necessary changes to the treatment plan.
- Developmental testing which should have occurred within the first two months of treatment.

- Information older than 30 days will be considered outdated and will not be accepted for review.

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