

SUBMIT TO
Utilization Management Department
 PHONE 1-855-650-3789 | FAX 1-844-481-6729



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 **DIAGNOSTIC AND TREATMENT INFORMATION**

Member Name: _____
 Medicaid ID#: _____
 Date of Birth: _____ Age: _____
 Phone Number: _____ Gender: M F

Primary Diagnosis (Required): _____
 Secondary: _____
 Prior Treatment relative to Diagnosis: _____

BILLING PROVIDER:

Provider Name: _____
 Tax ID#: _____
 Provider NPI#: _____
 Provider Address: _____
 Contact Name: _____
 Phone Number: _____
 Fax Number: _____
 HSSP/ Psychiatrist Physician

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: _____

SUPERVISING PROVIDER:

Provider Name: _____
 Group Facility Name: _____
 Tax Id#: _____
 Provider NPI#: _____
 Provider Address: _____
 Contact Name: _____
 Phone Number: _____
 Fax Number: _____

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 MODIFIER, IF APPLICABLE)

All out of network services require prior authorization, please indicated which codes below you are requesting

Code	Description	Units per Week/Month 1 unit = 15 min.	Total Unit
<input type="checkbox"/> 97151	Behavior Identification Assessment		
<input type="checkbox"/> 97152	Behavior Identification Supporting Assessment - by technician		
<input type="checkbox"/> 0362T	Behavior Identification Supporting Assessment - two or more technicians		
<input type="checkbox"/> 97162	Adaptive Behavior Treatment Protocol		
<input type="checkbox"/> 0373T	Adaptive Behavior Treatment with Protocol Modification - two or more technicians		
<input type="checkbox"/> 97155	Adaptive Behavior Treatment with Protocol Modification - by technician		
<input type="checkbox"/> 97154	Group Adaptive Behavior Treatment - by technician		

Code	Description	Units per Week/Month 1 unit = 15 min.	Total Unit
<input type="checkbox"/> 97158	Group Adaptive Behavior Treatment – two or more technicians		
<input type="checkbox"/> 97156	Family Adaptive Behavior Treatment Guidance - by technician		
<input type="checkbox"/> 97157	Family Adaptive Behavior Treatment Guidance – two or more technicians		

HSP 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 paraprofessionals 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.

Ambetter.HomeStateHealth.com

SUBMIT TO
Utilization Management Department
 PHONE 1-855-650-3789 | FAX 1-844-481-6729