SUBMIT TO
Utilization Management Department
PHONE 1.877.617.0390 | FAX 1.866.279.1358

APPLIED BEHAVIORAL ANALYSIS PRIOR AUTHORIZATION REQUEST FORM

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

MEMBER INFORMATION

Member Name:_____
Ambetter 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 5 41 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 INDICATE MODIFER, IF APPLICABLE)

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

Start Date:_____ End Date:_____

Codes	Description	Units per Week/Month	Total Units
97151	Behavior Identification assessment		
97152	Behavior identification supporting assessment		
0362T	Behavior identification supporting assessment (client and 2 or more techs, QHP on site)		
97153	Adaptive behavior treatment by protocol		
0373T	Adaptive behavior treatment with protocol modification (client and 2 or more techs, QHP on site)		

Codes	Description	Units per Week/Month	Total Units
97154	Group adaptive behavior treatment with protocol modification		
97155	Adaptive behavior treatment with protocol modification		
97156	Family adaptive behavior treatment guidance		
97157	Multiple family group adaptive behavior treatment guidance		
97158	Group adaptive behavior treatment with protocol modification		

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 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.

ambetterhealth.com/en/in

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