SUBMIT TO
Utilization Management Department
PHONE 1.800.224.1991 | FAX 1.866.694.3649

buckeye health plan

AUTISM SERVICES PRIOR AUTHORIZATION REQUEST FORM

Please print clearly- incomplete or illegible forms will delay processing.

MEMBER INFORMATION

Member Name: _____

Medicaid ID#: _____

Date of Birth: _____ Age: _____

Phone Number: _____ Gender: ☐ M ☐ F

BILLING PROVIDER: HSSP OR PHYSICIAN

Provider Name: _____

Tax ID#: _____

Provider NPI#: _____

Address: _____

Contact Name: _____

Phone Number: _____

Fax Number: _____

☐ HSSP/ Psychiatrist ☐ Physician

SUPERVISING PROVIDER: BCBA-D, BCBA, HSSP

Provider Name: _____

Group Facility Name: _____

Tax Id#: _____

Provider NPI#: _____

Address: _____

Contact Name: _____

Phone Number: _____

Fax Number: _____

DIAGNOSTIC AND TREATMENT INFORMATION

Primary (required): _____

Secondary: _____

Prior Treatment relative to Diagnosis: _____

_____

_____

Diagnosing Provider Name: _____

Diagnosis Date: _____

Date of last Initial Diagnostic Interview (IDI) or Functional Behavioral Assessment (FBA): _____

Standardized Tools used for Diagnosis: _____

_____

_____

Is the member in school? ☐ Yes ☐ No

Does the member have an IEP or 504 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 out of network services require prior authoirzation, please indicated which codes below you are requesting

Start Date: _____ End Date: _____

***Please note that prior authorization is required. Retrospective dates will not be processed. Please submit retrospective date requests to: 866.714.7991**

Code	Description	Units per Week/Month	Total Unit
☐ 0359T	Behavior Identification Assessement 1 unit= 30 minutes		
☐ 0364T	Adaptive behavior treatment by protocol; first 30 minutes 1 unit= 30 minutes		
☐ 0365T	Adaptive behavior treatment by protocol; each additional 30 minutes 1 unit= 30 minutes		
☐ 0368T	Adaptive behavior treatment with protocol modification; first 30 minutes 1 unit= 30 minutes		
☐ 0369T	Adaptive behaviot treatment with protocol modification; each additional 30 minutes 1 unit= 30 minutes		

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 standarized measures and referral from diagnosing provider for ABA services to include estimated duration of care. The latest Initial Diagnostic Interview (IDI) and, if applicable, the Functional Behavioral Assessment (FBA) is required.

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.

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.