SUBMIT TO
Utilization Management Department
PHONE 1.800.224.1991 | FAX 1.866.694.3649

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: ______________________________

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Diagnosing Provider Name: ______________________________

Diagnosis Date: ______________________________

Date of Last Initial Diagnostic Interview (IDI) or Functional Behavioral Assessment (FBA): ______________________________

Standardized Tools Used for Diagnosis: ______________________________

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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: ______________________________

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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 authorization, 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**

Codes	Description (1 unit = 15 minutes)	Units per Week/Month	Total Units
☐ 97151	Behavior identification assessment *Prior Auth required for out-of-network only.*		
☐ 97152	Behavior identification supporting assessment *Prior Auth required for out-of-network only.*		
☐ 97153	Adaptive behavior treatment by protocol		
☐ 97154	Group adaptive behavior treatment by protocol		
☐ 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		

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.