

SUBMIT TO

Utilization Management Department

PHONE 1-877-647-4848 | FAX 1-866-694-3649



APPLIED BEHAVIORAL ANALYSIS (ABA) OUTPATIENT TREATMENT 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 or delay processing.

MEMBER INFORMATION

Member Name: _____

Medicaid ID#: _____

Phone Number: _____

Date of Birth: _____ Age: _____

Gender: Male Female Not Identified

Additional insurance: Yes No

Additional insurance name/policy #: _____

BILLING PROVIDER INFORMATION

Provider Name: _____

Provider NPI#: _____

Tax ID#: _____

Provider Phone: _____

Group/Facility Name: _____

Group/Facility Address: _____

Phone Number: _____

Fax Number: _____

DIAGNOSTIC AND TREATMENT INFORMATION

Primary Diagnosis: _____

Date of diagnosis: _____

Diagnosing Provider/Doctor: _____

Standardized Tool Used for Autism Diagnosis

Test Initial Test Date and Score Test Initial Test Date and Score

ADI-R _____ CARS-2 _____

ADOS _____ MCHAT _____

ASSQ _____ Other _____

GARS _____

Additional Diagnosis: Yes No if yes, diagnosis, dates and diagnosing provider: _____

Any medical conditions that will impact outcomes of treatment: Yes No

If yes, list: _____

Medication: Yes No If yes, list: _____

Prior and Current Treatment Related to Primary Diagnosis:

Intervention	Past service Start/end dates, or N/A if not applicable	Current service start date, or N/A if not applicable	Additional information, description, related service	Schedule of services
IFSP (include related services)				
IEP (include related services)				
504 Plan				
ABA				
OT private				
PT private				
SP/L therapy private				
General education				
Homeopathic therapy				

BASELINE AND ASSESSMENT INFORMATION

Date Current Assessment Completed: ____ / ____ / ____

Assessment Participants:

Conducted by (name): _____

Patient Only Parents/Caregivers Only Patient and Parents/Caregivers

License/Certification: _____

Please select at least one (1) instrument that will be utilized for the member's entire treatment episode so progress can effectively be measured. Choose a recognized instrument such as the VB MAPP, ABLLS, AFLS, PEAK, or the Vineland.

Name of Assessment	Current Test Date	Current Score	Previous Test Date	Previous Test Score
Name of Assessment	Current Test Date	Current Score	Previous Test Date	Previous Test Score

Also, please attach standardized measurement scoring summaries if the member has been in treatment prior to this request.

CURRENT DISRUPTIVE BEHAVIORS

- (1) Behavior: _____
Frequency: _____ per hour day week
- (2) Behavior: _____
Frequency: _____ per hour day week
- (3) Behavior: _____
Frequency: _____ per hour day week
- (4) Behavior: _____
Frequency: _____ per hour day week

CURRENT COMMUNICATION AND SOCIAL SKILLS

- Vocal:** How Many Mands _____
Describe communication: _____
- Non Vocal:** Device Used _____
Describe communication: _____
- Describe Social Skills (family relationships, interaction with adults and peers, what does play look like?: _____

AUTHORIZATION REQUEST

Please note that retrospective dates will not be processed. Please submit retrospective date requests to: 1-866-714-7991

Start Date: _____ End Date: _____ Is the request: Focused Comprehensive Initial Concurrent

For Concurrent Requests: What is the current prescription fulfillment rate? (on average how many hours a week are services rendered versus authorized for the request? What factors impact the units used, including member/family illness, transportation barriers, etc):

Codes (market specific allowable codes and Description per time (15 minutes) Market specific (for example, IA)	Frequency: How often seen (per week/month)	Total units requested per authorization time frame
<input type="checkbox"/> 97151 Behavior identification assessment		
<input type="checkbox"/> 97152 Behavior identification supporting assessment		
<input type="checkbox"/> 0362T Behavior identification supporting assessment (client and 2 or more techs, QHP on site)		
<input type="checkbox"/> 97153 Adaptive behavior treatment by protocol		
<input type="checkbox"/> 0373T Adaptive behavior treatment with protocol modification (client and 2 or more techs, QHP on site)		
<input type="checkbox"/> 97154 Group adaptive behavior treatment by protocol		
<input type="checkbox"/> 97155 Adaptive behavior treatment with protocol modification		
<input type="checkbox"/> 97156 Family adaptive behavior treatment guidance		
<input type="checkbox"/> 97157 Multiple family group adaptive behavior treatment guidance		
<input type="checkbox"/> 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 treatment requests:

- Diagnostic evaluations and assessments
- Recommendation ABA from a qualified provider
- Proposed treatment schedule, including related therapy and naps.
- Proposed functional and measureable treatment goals with expected time frames with target identified behavioral deficits
- Proposed plan for parent/caregiver involvement and performance based parent goals and baseline
- Functional Behavior Assessment/FA and BIP

For subsequent treatment request:

- Updated assessment information
- Any developmental testing which should have occurred within the first two months of treatment.
- Summary of member status, e.g., changes in medication, social, progress to date, schedule
- Objective measures of current status and clinically significant progress towards each stated treatment goal
- Performance based parent/caregiver goal progress and updated goals
- Timeline for achievement of goals
- Updated ABA FBA/FA and BIP
- If there is an increase or decrease in hours requested, include a description explaining why the hours are being modified

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.