SUBMIT TO
Utilization Management Department
PHONE 1-877-647-4848 | FAX 1-866-694-3649

APPLIED BEHAVIORAL ANAYLSIS (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: _____ / _____ / _____

Conducted by (name): _____

License/Certification: _____

Assessment Participants:

☐ Patient Only ☐ Parents/Caregivers Only ☐ Patient and Parents/Caregivers

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
☐ 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)		
☐ 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 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.