ABA Prior Authorization Request

****Chart Notes Required****

Please fax to Behavioral Health: 503-574-8110 | Questions please call: 503-574-6400

Note: This form may only be used to request ABA services.

Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	Phone:
Address:	Date of Service:	Date Span Requested:

Primary Care Physician (PCP):	
Requesting Provider:	TIN#:
Address:	NPI#:
Servicing Provider:	TIN#:
Address:	NPI#:
Servicing Facility:	TIN#:
Address:	NPI#:

Requested Item/Service:

ICD-10 Code(s): **(Please attach diagnostic evaluation by qualified professional)**	CPT Code(s):

In-Network Benefits: **Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility.** ☐ New Patient ☐ Established Patient | Date last seen _____

Explanation Required:

****REQUIRED** Utilization Review Contact Information:**		
Name:	Phone #:	Fax#:

IMPORTANT NOTICE: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message by error, please notify us immediately and destroy the related message.

ABA AUTHORIZATION REQUEST

Use this form for both initial and concurrent requests. Please indicate the type of request, as well as the type of services requested. Include the number of requested units as well as hours per day, and hours or days per week, as indicated. Please submit a complete treatment plan with this request.

Patient's Name: _____ **ID#:** _____

Requested Start Date for this Authorization: _____

Request for:

☐ Initial Assessment ☐ Initial Treatment ☐ Concurrent Request

SERVICES REQUESTED

(All units are 15 minutes; 4 units equal 1 hour)

Program setting and hours per week:

☐ Home _____ ☐ Facility/Clinic _____ ☐ School _____ ☐ Other: _____

Assessment / Follow-up Assessment

By physician or other qualified health care professional (QHP). Behavior identification assessment, administration of tests, detailed behavioral history, observation, caretaker interview, interpretation, discussion of findings, recommendations, preparation of report, development of treatment plan. Assessment of strengths and weaknesses of skill areas across skill domains (e.g., VB-MAPP, ABLLS-R, Functional Behavior Assessment, Functional Analysis) and follow-up assessments.

☐ **97151:** Behavior identification assessment (initial or reassessment) administered by a physician/QHP. Units are in 15-minute increments; up to 32 units for initial, up to 24 units for reassessment.

Units Requested: _____

☐ **97152:** Behavior identification supporting assessment administered by technician under direction of physician/ QHP, face to face with patient. Units are in 15-minute increments. **Clinical justification required.**

Units Requested: _____

☐ **0362T:** Behavior identification supporting assessment for severe behaviors administered by a physician/QHP who is on-site, with the assistance of two or more technicians, for a patient who exhibits destructive behavior, completed in an environment that is customized to a patient's behavior. Units are in

15-minute increments. **Clinical justification required.**

Units Requested: _____

Direct 1:1 ABA Therapy

☐ **97153:** Adaptive behavior treatment by protocol administered by technician under the direction of physician/QHP, receiving 1 hour of supervision for every 5 to 10 hours of direct treatment. Units are in 15-minute increments.

Hours per week: _____ Units Requested: _____

☐ **97155:** Adaptive behavior treatment with protocol modification, administered by physician/QHP. May be used for **Direction of Technician (Supervision)** face-to-face with one patient. Units are in 15-minute increments.

Hours per day: _____Days per week: _____Units Requested: _____

☐ **0373T:** Adaptive behavior treatment with protocol modification implemented by physician/QHP who is on-site with the assistance of two or more technicians for severe maladaptive behaviors. Units are in 15-minute increments. **Clinical justification required.**

Hours per week: _____Units Requested: _____

Group Adaptive Behavior Treatment

☐ **97154:** Group adaptive behavior treatment by protocol by technician under the direction of physician/QHP, face-to-face with two or more patients. Units are in 15-minute increments.

Hours per day: _____Days per week: _____Units Requested: _____

☐ **97158:** Group adaptive behavior treatment with protocol modification **(Social Skills Group)** by physician/QHP**,** face-to-face with two or more patients. Units are in 15-minute increments.

Hours per day: _____Days per week: _____Units Requested: _____

Family Adaptive Behavior Treatment Guidance (Family Training)

By physician/QHP, with or without the patient.

☐ **97156:** With individual family. Units are in 15-minute increments.

Hours per week: _____ Units Requested: _____

☐ **97157:** With multiple family group. Units are in 15-minute increments.

Hours per week: _____ Units Requested: _____