

SUBMIT TO

Utilization Management Department

PHONE 1.844.366.2880 | FAX 1.855.868.4940



APPLIED BEHAVIORAL ANALYSIS (ABA) 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 541 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 MODIFIER, IF APPLICABLE)

All out of network services require prior authorization, please indicated which codes below you are requesting

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
Adaptive Behavior Treatment administered by Technician (Face-to-face with one patient; first 30 minutes of technician time) <input type="checkbox"/> 0364T					
Adaptive Behavior Treatment administered by Technician (Each additional 30 minutes of technician time) <input type="checkbox"/> 0365T					
Adaptive Behavior Treatment administered by Physician or QHP (First 30 minutes of patient face-to-face time) <input type="checkbox"/> 0368T					
Adaptive Behavior Treatment administered by Physician or QHP (Each additional 30 minutes of patient face-to-face time) <input type="checkbox"/> 0369T					
Exposure Adaptive Behavior Treatment Two or More Technicians for Severe Maladaptive Behavior(s) (First 60 minutes of technicians' time face-to-face with patient) <input type="checkbox"/> 0373T					

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
Exposure Adaptive Behavior Treatment Two or More Technicians for Severe Maladaptive Behavior(s) (Each additional 30 minutes of technicians' time face-to-face with patient) <input type="checkbox"/> 0374T					
Group Adaptive Behavior Treatment administered by Technician (Face-to-face with two or more patients; first 30 minutes of technician time) <input type="checkbox"/> 0366T					
Group Adaptive Behavior Treatment administered by Technician (Each additional 30 minutes of technician time) <input type="checkbox"/> 0367T					
Group Adaptive Social Skills Treatment administered by Physician or QHP (Face-to-face with multiple patients) <input type="checkbox"/> 0372T					
Family Adaptive Behavior Treatment Guidance administered by Physician or QHP (Without patient present) <input type="checkbox"/> 0370T					
Family Adaptive Behavior Treatment Guidance administered by Physician or QHP (With patient present) <input type="checkbox"/> S5110					

For applicable service requests, please include the following information and corresponding clinical documentation: LOCUS/CASII Score _____ Intensity of Needs Level _____

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 standardized 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.

- The medical information can be found at: www.NebraskaTotalCare.com.
- Information older than 30 days will be considered outdated and will not be accepted for review.

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 paraprofessionals rendering service under the proposed treatment plan have the appropriate training and education required to render services.