SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
Phone 1-866-534-5976 | Fax 1-866-694-3649

Autism Spectrum Disorder Authorization Form

MEMBER INFORMATION

Member Name: ______________________ Medicaid ID #: ______________________

Date of Birth: ______________________ Phone #: ______________________

Age: ______________________ Gender: ☐ Male ☐ Female

BILLING PROVIDER

Provider Name: ______________________ Tax ID: ______________________

Provider NPI: ______________________ Provider Address: ______________________

Contact Name: ______________________ ______________________

Phone #: ______________________ Fax #: ______________________

SUPERVISING PROVIDER

Provider Name: ______________________ Group/Facility Name: ______________________

Tax ID: ______________________ Provider NPI: ______________________

Provider Address: ______________________ Phone #: ______________________

______________________ Fax #: ______________________

DIAGNOSTIC AND TREATMENT INFORMATION

Primary Diagnosis (Required): ______________________ Secondary: ______________________

Prior Treatment Relative to Diagnosis: ______________________

Standardized Tools Used for Diagnosis: ______________________

☐ OP MH ☐ OP SA ☐ IP MH ☐ IP SA/Detox ☐ None

Diagnosis Date: ______________________ Is this member in school? ☐ Yes ☐ No

Medical conditions as reported by parent or gaurdian: ______________________

List prescribed medications and dosages: ______________________

Does the member have an IEP or 540 plan? ☐ Yes ☐ No Does the member receive early intervention services? ☐ Yes ☐ No

Please describe other services received in addition to the ABA requested, including but not limited to, PT, OT, ST, or mental health services: ______________________

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Is this an intitial request for authorization? ☐ Yes ☐ No Date of ASD treatment: ______________________

Date of most recent reassessment: ______________________

AUTHORIZATION INFORMATION

Start Date: ______________________________ End Date: ______________________________________

*Please note that prior authorization is required. Retrospective dates will not be processed. Please submit retrospective date requests to: 1-866-714-7991

SERVICE	FREQUENCY: How Often Seen	INTENSITY: # of Units per Visit	REQUESTED Start Date for this Authorization	ANTICIPATED Completion of Service
Board Certified Behavior Analyst (BCBA)				
Board Certified Assistant Behavior Analyst (BCaBC)				
Behavior Identification Assessment (ASD) ☐ 0359T				
Adaptive Behavior Treatment with Protocol Modification ☐ 0368T ☐ 0369T				
Registered Behavior Technician II (RBT I)				
Observational Behavioral Follow-up Assessment ☐ 0360T ☐ 0361T				
Registered Behavior Technician I (RBT I)				
Exposure Behavioral Follow-up Assessment ☐ 0362T ☐ 0363T				
Adaptive Behavior Treatment by Protocol ☐ 0364T ☐ 0365T				
Licensed Independent Practitioners (LIPs)				
Therapeutic Behavior Service (non- ASD) ☐ H2019				
Diagnostic Evaluation (non-ASD) ☐ 90791				

Please submit the information noted below with all treatment requests. If documentation is not received, the request will be reviewed based on the information available at the time of 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.

For initial treatment plan please submit:

- Objective testing showing significant behavioral deficit.
- Description of coordination of services with other providers (e.g. school, PT, OT, ST).
- Proposed treatment schedule including the provider type who will render services.
- Proposed functional, and measureable treatment goals with expected time frames 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.

Supervising Provider Signature: ____ Date: ____________________

By signing above, I attest that I am actively participating in the treatment plan and coordinating services for the member.

Billing Provider Signature: ____ Date: ____________________

By signing 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.