Applied Behavioral Analysis (ABA) Authorization Form

MEMBER INFORMATION

Member Name: _____ Medicaid ID #: _____

Date of Birth: _____ Phone Number: _____

Age: _____ Gender: ☐ Male ☐ Female

BILLING PROVIDER: HSPP OR PHYSICIAN

Provider Name: _____ Tax ID: _____

Provider NPI: _____ Provider 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: _____

Provider Address: _____ Phone Number: _____

_____ Fax Number: _____

DIAGNOSTIC AND TREATMENT INFORMATION

Primary Diagnosis (Required): _____ Secondary: _____

Prior Treatment Relative to Diagnosis: _____

Standardized Tools used for Diagnosis: _____

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

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

Plese discribe other services received in addtion to the ABA requested, including but not limited to, PT, OT, ST or mental health services: _____

_____

Is this an intitial request for authorization? ☐ Yes ☐ No Date of ABA treatment: _____

Date of most recent reassessment: _____

SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
PHONE 1.877.647.4848| FAX 1.866.694.3649

AUTHORIZATION INFORMATION

Start Date: _____ End Date: _____

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

Code	Modifer	Description	Units per Week/Month 1 unit = 15 min.	Total Unit
96150	U1	Health and Behavior Assessment, face-to-face, initial assessment Provided by BCBA, BCBA-D, or HSSP		
96150	U2	Health and Behavior Assessment, face-to-face, initial assessment Provided by BCaBA		
96151	U1	Health and Behavioral Assessment re-assessment Provided by BCBA, BCBA-D, or HSPP		
96151	U2	Health and Behavior Assessment re-assessment Provided by BCaBA		
96152	U1	Health and Behavior Intervention, individual Provided by BCBA, BCBA-D, HSPP		
96152	U2	Health and Behavior Intervention, individual Provided by BCaBA		
96152	U3	Health and Behavior Intervention, individual Provided by RBT		
96153	U1	Health and Behavior Intervention, group Provided by BCBA, BCBA-D, HSPP		
96153	U2	Health and Behavior Intervention, group Provided by BCaBA		
96153	U3	Health and Behavior Intervention, group Provided by RBT		
96154	U1	Health and Behavior Intervention, family with patient present Provided by BCBA, BCBA-D, HSPP		
96154	U2	Health and Behavior Intervention, family with patient present Provided by BCaBA		
96154	U3	Health and Behavior Intervention,family with patient present Provided by RBT		
96155	U1	Health and Behavior Intervention, family without patient present Provided by BCBA, BCBA-D, HSPP		
96155	U2	Health and Behavior Intervention, family without patient present Provided by BCaBA		
96155	U3	Health and Behavior Intervention, family without patient present Provided by RBT		

HSPP or Physician Signature: _____ Date: _____

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

Rendering 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.

ADDITIONAL INFORMATION

Please submit the information noted below with all treatment requests. If documentation is not received, the request will be reviewed based on the informati 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:

- o Objective testing showing significant behavioral deficit.
- o Description of coordination of services with other providers (school, PT, OT, ST)
- o Proposed treatment schedule including the provider type who will render services
- o Proposed functional, and measureable treatment goals with expected timeframes which target identified behavior deficits
- o Proposed plan for parent involvement and training and parent's goals for outcomes
- o Any medical conditions that will impact outcomes of treatment
- o Copy of IEP or IFSP if applicable

For subsequent treatment requests please submit:

- o Objective measures of current status
- o Objective measures of clinically significant progress towards each stated treatment goal
- o Updated plan for treatment including updated goals and timeline for achievement
- o Any necessary changes to the treatment plan
- o Developmental testing which should have occurred within the first two months of treatment

The medical necessity policy can be found at: www.mhsindiana.com

Information older than 30 days will be considered outdated and will not be accepted for review

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