

SUBMIT TO
Utilization Management Department
 13620 FM 620, Bldg C, Suite 300
 Austin, Texas 78717
 PHONE 1.844.385.2192 | FAX 1.866.593.1955



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: _____
 Phone Number: _____
 Age: _____ 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: _____

AUTHORIZATION INFORMATION

Please note that prior authorization is required. Retrospective dates will not be processed. Please submit retrospective date requests to:

Code	Description	Time	Total Units Requested
<input type="checkbox"/> 97151	Behavior Identification Assessment	Per 15 minutes	
<input type="checkbox"/> 97152	Behavior Identification Supporting Assessment – by technician	Per 15 minutes	
<input type="checkbox"/> 0362T	Behavior Identification Supporting Assessment – two or more technicians	Per 15 minutes	
<input type="checkbox"/> 97153	Adaptive Behavior Treatment Protocol	Per 15 minutes	
<input type="checkbox"/> 0373T	Adaptive Behavior Treatment with Protocol Modification – two or more technicians	Per 15 minutes	
<input type="checkbox"/> 97155	Adaptive Behavior Treatment with Protocol Modification – by technician	Per 15 minutes	
<input type="checkbox"/> 97154	Group Adaptive Behavior Treatment – by technician	Per 15 minutes	
<input type="checkbox"/> 97158	Group Adaptive Behavior Treatment – two or more technicians	Per 15 minutes	
<input type="checkbox"/> 97156	Family Adaptive Behavior Treatment Guidance – by technician	Per 15 minutes	
<input type="checkbox"/> 97157	Family Adaptive Behavior Treatment Guidance – two or more technicians	Per 15 minutes	

Start Date: _____

End Date: _____

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 measurable 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.

- 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.