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.

Medicad (Def. Secondary: Prior Treatment (relative to Diagnosis: Prior Treatment (Palve) Diagnosis Date: Diagnosis: Diagnosis Date: Diag	MEMBER INF	FORMATION	DIAGNOSTIC AND T	REATMENT INFORI	MATION	
Secondary:	Member Name:		Primary (required):			
Prior Treatment relative to Diagnosis:						
Age: Gender: M F Diagnosing Provider Name: Diagnosing Provider Name: Diagnosing Provider Name: Search (IRA): Diagnosis Date: Diagnosis Clate: Massessment (IRA): Standardized Tools used for Diagnosis: Search (IRA): Standardized Tools used for Diagnosis:						
Diagnosis Date: Date of last Initial Diagnosis Interview (IDI) or Functional Behavioral Assessment (FBA): Standardized Tools used for Diagnosis: Standar	Phone Number:		_		 	
Provider Name: Tax ID#: Standardized Tools used for Diagnosis: Standardized Tools untermether in school? Standardized Tools untermether in school? Standardized Tools untermet	Age:	Gender: M F	Diagnosing Provider Name:			
Assessment (FBA): Tax UB*: Provider NPI8: Address: Contact Name: Phone Number: Provider NPI9: Address: Does the member in school? Does the member have an IEP or 541 plan? Does the member have an IEP or 541 plan? Does the member have an IEP or 541 plan? Does the member have an IEP or 541 plan? Does the member received in addition to the ABA requested to including but not limited to: PT, OT, ST or mental health services: Group Facility Name: Tax Id#: Provider NPI8: Address: Contact Name: Provider Name: Group Facility Name: Tax Id#: Provider NPI8: Address: Contact Name: Date ABA Treatment Initiated: Date of most recent reassessment: 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 Per 15 minutes Par 15 minutes	BILLING PRO	OVIDER: HSSP OR PHYSICIAN	Diagnosis Date:			
Assessment (FBA):	Provider Name:		Date of last Initial Diagnostic	Interview (IDI) or Functiona	l Behavioral	
Provider NPIB: Address: Contact Name:			Assessment (FBA):			
Address: Contact Name:			Standardized Tools used for I	Diagnosis:		
Contact Name: Is the member in school? Ves No No No No No No No N						
Phone Number:			_			
Does the member receive early intervention services? Yes No SUPERVISING PROVIDER: BCBA-D, BCBA, HSSP					☐ Yes ☐ No	
Does the member receive early intervention services? Yes No	Fax Number:		Does the member have an IE	P or 541 plan?	☐ Yes ☐ No	
Provider Name:						
Provider Name:	SUPERVISING PROVIDER: BCBA-D, BCBA, HSSP		Please describe other service	Please describe other services received in addition to the ABA requested to		
Group Facility Name:	Provider Name		including but not limited to: P	T, OT, ST or mental health s	services:	
Tax Id#:						
Provider NPI#:			-			
Address:			Is this an initial request for au	thorization?	☐ Yes ☐ No	
Contact Name:			Date ABA Treatment Initiated:			
AUTHORIZATION INFORMATION Please note that prior authorization is required. Retrospective dates will not be processed. Please submit retrospective date requests to: Code			Date of most recent reassess	ment:		
AUTHORIZATION INFORMATION Please note that prior authorization is required. Retrospective dates will not be processed. Please submit retrospective date requests to: Code	Phone Number:					
AUTHORIZATION INFORMATION Please note that prior authorization is required. Retrospective dates will not be processed. Please submit retrospective date requests to: Code			_			
Please note that prior authorization is required. Retrospective dates will not be processed. Please submit retrospective date requests to: Code	AUTHORIZAT	TION INFORMATION				
97151 Behavior Identification Assessment Per 15 minutes 97152 Behavior Identification Supporting Assessment – by technician Per 15 minutes 0362T Behavior Identification Supporting Assessment – two or more technicians Per 15 minutes 97153 Adaptive Behavior Treatment Protocol Per 15 minutes 0373T Adaptive Behavior Treatment with Protocol Modification – two or more technicians Per 15 minutes 97155 Adaptive Behavior Treatment with Protocol Modification – by technician Per 15 minutes 97154 Group Adaptive Behavior Treatment – by technician Per 15 minutes 97158 Group Adaptive Behavior Treatment – two or more technicians Per 15 minutes 97156 Family Adaptive Behavior Treatment Guidance – by technician Per 15 minutes 97157 Family Adaptive Behavior Treatment Guidance – two or more technicians Per 15 minutes Start Date:			pe processed. Please submit retros	pective date requests to:		
97151 Behavior Identification Assessment Per 15 minutes 97152 Behavior Identification Supporting Assessment – by technician Per 15 minutes 0362T Behavior Identification Supporting Assessment – two or more technicians Per 15 minutes 97153 Adaptive Behavior Treatment Protocol Per 15 minutes 0373T Adaptive Behavior Treatment with Protocol Modification – two or more technicians Per 15 minutes 97155 Adaptive Behavior Treatment with Protocol Modification – by technician Per 15 minutes 97154 Group Adaptive Behavior Treatment – by technician Per 15 minutes 97158 Group Adaptive Behavior Treatment – two or more technicians Per 15 minutes 97156 Family Adaptive Behavior Treatment Guidance – by technician Per 15 minutes 97157 Family Adaptive Behavior Treatment Guidance – two or more technicians Per 15 minutes Start Date:						
Behavior Identification Assessment — by technician — Per 15 minutes — 97152 — Behavior Identification Supporting Assessment — by technician — Per 15 minutes — 97153 — Behavior Identification Supporting Assessment — two or more technicians — Per 15 minutes — 97153 — Adaptive Behavior Treatment Protocol — Per 15 minutes — 97155 — Adaptive Behavior Treatment with Protocol Modification — two or more technicians — Per 15 minutes — 97155 — Adaptive Behavior Treatment with Protocol Modification — by technician — Per 15 minutes — 97154 — Group Adaptive Behavior Treatment — by technician — Per 15 minutes — 97158 — Group Adaptive Behavior Treatment — two or more technicians — Per 15 minutes — 97156 — Family Adaptive Behavior Treatment Guidance — by technician — Per 15 minutes — 97157 — Family Adaptive Behavior Treatment Guidance — two or more technicians — Per 15 minutes — Per 15 minutes — 97157 — Family Adaptive Behavior Treatment Guidance — two or more technicians — Per 15 minutes — Pe	Code	Description		Time		
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Behavior Identification Supporting Assessment – two or more technicians 97153						
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□ 97155 Adaptive Behavior Treatment with Protocol Modification – by technician Per 15 minutes □ 97154 Group Adaptive Behavior Treatment – by technician Per 15 minutes □ 97158 Group Adaptive Behavior Treatment – two or more technicians Per 15 minutes □ 97156 Family Adaptive Behavior Treatment Guidance – by technician Per 15 minutes □ 97157 Family Adaptive Behavior Treatment Guidance – two or more technicians Per 15 minutes Start Date:	97153	Adaptive Behavior Treatment Protocol		Per 15 minutes		
□ 97154 Group Adaptive Behavior Treatment – by technician Per 15 minutes □ 97158 Group Adaptive Behavior Treatment – two or more technicians Per 15 minutes □ 97156 Family Adaptive Behavior Treatment Guidance – by technician Per 15 minutes □ 97157 Family Adaptive Behavior Treatment Guidance – two or more technicians Per 15 minutes Start Date:	☐ 0373T	Adaptive Behavior Treatment with Protocol Modification – two or more technicians		Per 15 minutes		
□ 97158 Group Adaptive Behavior Treatment – two or more technicians Per 15 minutes □ 97156 Family Adaptive Behavior Treatment Guidance – by technician Per 15 minutes □ 97157 Family Adaptive Behavior Treatment Guidance – two or more technicians Per 15 minutes Start Date:	97155	Adaptive Behavior Treatment with Protocol Modification – by technician		Per 15 minutes		
□ 97156 Family Adaptive Behavior Treatment Guidance – by technician Per 15 minutes □ 97157 Family Adaptive Behavior Treatment Guidance – two or more technicians Per 15 minutes Start Date:	97154	Group Adaptive Behavior Treatment – by technician		Per 15 minutes		
97156 Family Adaptive Behavior Treatment Guidance – by technician Per 15 minutes 97157 Family Adaptive Behavior Treatment Guidance – two or more technicians Per 15 minutes Start Date:	97158	Group Adaptive Behavior Treatment – two or more technicians		Per 15 minutes		
97157 Family Adaptive Behavior Treatment Guidance – two or more technicians Per 15 minutes Start Date:		Family Adaptive Behavior Treatment Guidance – by technician		Per 15 minutes		
		Family Adaptive Behavior Treatment Guidance – two or more technicians Per 15 minutes				
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	Start Date:			NEDDACKA TO	TAL CARE DAGE 4	

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.

education required to render services.

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.Nebras	skaTotalCare.com.
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Information older than 30 da	ys will be considered outdated a	and will not be accepted for review
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HSPP or Physician Signature:	Date:
By signing the above, I attest that I am actively participating in the treatment p	plan and coordinating services for the member.
Rendering Provider Signature:	Date:
By signing the above, I attest that all professionals and paraprofessinals rend	lering service under the proposed treatment plan have the appropriate training and