

Applied Behavior Analysis (ABA) Services Prior Authorization Request Form

Request completed by: _____ Phone #: _____ Fax #: _____
 Date of Request: _____ Total Number of Pages: _____
 Authorization on File (check one): Yes ___ No ___ If Yes, Date of Last Scheduled Visit: _____
 Is the member diagnosed with Autism Spectrum Disorder (ASD) (check one) – F84.0? Yes ___ No ___
 • If not, what is the current diagnosis code(s): _____

Member Information

Member Name: _____ Member ID #: _____ DOB: _____
 Other Insurance(check one): Yes ___ No ___ If yes please specify: _____
 Phone #: _____

Behavioral Health Home

Provider Name: _____
 Address: _____
 Phone #: _____ Fax #: _____
 Member receiving High Needs Case Management(check one): Yes ___ No ___
 Contact Name and Phone #: _____

Rendering Service Provider Information

Provider Name: _____ TIN/NPI#: _____
 Address: _____
 Phone #: _____ Fax #: _____

Credentials for provider delivering clinical direction and supervision:

___ BCBA ___ BCBA-D ___ LBA ___ Behavior Health Professional ___ Other (specify): _____

Assessment & Treatment

ABA Therapy being requested (**required**)(check one): ___ Focused or ___ Comprehensive

Please ensure the following has been included in your request:

- Assessment findings:
 - a. Brief description of assessments, including their purpose;
 - Indirect Assessments: Summary of findings for each assessment (graphs, tables, or grids);
 - Direct Assessments: Summary of findings for each assessment (graphs, tables or grids);
 - b. Target behaviors are operationally defined, including baseline levels;
 - c. Functional Behavior Assessment, if applicable.
- Individualized Treatment plan should include the following:
 - Treatment setting and modality by which service will be delivered (in-person, via telehealth, group, individualized setting, or combination thereof);
 - Operational definition of each behavior/goal/skill;

- Data collection procedures;
- Behavior management/treatment protocols;
- Treatment goals and objectives;
- Parent/caregiver training procedures and goals/objectives;
- Plan to ensure maintenance and generalization of skills;
- Care coordination activities;
- Discharge criteria clearly defined and measurable.

Standard Assessment Information (required)

* On re-authorization, must complete a re-assessment every 6 months

- Type of Assessment completed: _____
- Current Score: _____ Date: _____

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- Current Score: _____ Date: _____

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CPT and Hours of Supervision and Therapy

The following timeframes are needed to report to AHCCCS:

- Hours of direct therapy for entire authorization timeframe: _____
- Hours of supervision provided for entire authorization timeframe: _____

CPT Code(s):

Example for Therapy & Supervision for 6 months

CPT	Purpose: Direct Therapy or Supervision	Hours Per Week	Units Per Week	Timeframe in weeks	Total units
97153	Therapy	40 hours week	160 week	24 weeks	3,840
97155	Supervision	12 hours week	48 week	24 weeks	1,152

*Purpose: Due to reporting requirements, enter separate line to distinguish supervision vs therapy.

PROVIDER TO FILL IN FOR ALL CPT codes

CPT	Purpose: Direct Therapy or Supervision	Hours Per Week	Units Per Week	Timeframe in weeks	Total Units
97153	Supervision				
97153	Therapy				
97154	Therapy				
97155	Supervision				
97155	Therapy				
97156	Therapy				
97157	Therapy				
97158	Therapy				