1199SEIU Benefit Funds
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APPLIED BEHAVIOR ANALYSIS (ABA) PRIOR AUTHORIZATION FORM

Please indicate the type of request you are seeking authorization for:

☐ A. Initial/continued ABA healthcare request

☐ B. Reconsideration request

If A., you are required to submit current (within the past 12 months) supporting clinical information.

Provide requested start date for new authorization: _____

If B., you are required to submit any additional or new clinical information that was not considered at the time of the initial review.

I. PATIENT INFORMATION:

_____
1199SEIU MEMBER ID #

_____ _____ _____
PATIENT'S FIRST NAME | PATIENT'S LAST NAME | DATE OF BIRTH (MM/DD/YYYY)

_____ _____ _____ _____
ADDRESS | CITY | STATE | ZIP CODE

Patient/Caregiver Contact Information:

_____ _____ _____
EMAIL ADDRESS | CELL PHONE | BEST TIME TO CALL

Is the patient diagnosed with Autism Spectrum Disorder (F84.0)? ☐ Yes ☐ No

If Yes, please provide:

Date of most current diagnostic evaluation: _____

Evaluator's name and credentials: _____

Please list any other relevant diagnoses and their diagnostic codes:

_____

_____

_____

_____

II. PROVIDER INFORMATION AND CREDENTIALS:

CLINIC NAME

CLINIC/PRACTICE ADDRESS | CITY | STATE | ZIP CODE

FACILITY TAX ID# | NPI#

PHONE NUMBER | FAX NUMBER

EMAIL ADDRESS

INDIVIDUAL SUPERVISING PROVIDER'S NAME | INDIVIDUAL SUPERVISING PROVIDER'S TAX ID AND NPI #

The supervising provider is credentialed or licensed as (Please check all that apply):

☐ BCBA ☐ BCBA-D ☐ LBA ☐ Licensed Psychologist ☐ Other (Please specify): _____

Is the provider above providing all supervision for the patient's ABA treatment? ☐ Yes ☐ No

If No, please list who else is providing supervision and their credentials:

_____

_____

_____

How many ABA assessment units are you requesting during the authorization period:

Assessment Units:

97151: _____ units _____ hours ☐ per week ☐ per month:_____ total number of units per authorization period: _____

97152: _____ units _____ hours ☐ per week ☐ per month:_____ total number of units per authorization period: _____

BCBA/Supervision Units/Hours and Frequency:

97155: _____ units _____ hours ☐ per week ☐ per month:_____ total number of units per authorization period: _____

97156: _____ units _____ hours ☐ per week ☐ per month:_____ total number of units per authorization period: _____

97157: _____ units _____ hours ☐ per week ☐ per month:_____ total number of units per authorization period: _____

97158 _____ units _____ hours ☐ per week ☐ per month:_____ total number of units per authorization period: _____

0373T: _____ units _____ hours ☐ per week ☐ per month:_____ total number of units per authorization period: _____

0362T: _____ units _____ hours ☐ per week ☐ per month:_____ total number of units per authorization period: _____

Technician/RBT Hours and Frequency:

97153: _____ units _____ hours ☐ per week ☐ per month:_____ total number of units per authorization period: _____

97154: _____ units _____ hours ☐ per week ☐ per month:_____ total number of units per authorization period: _____

ABA treatment place of service (Please check all that apply):

☐ Clinic ☐ Home ☐ School ☐ Community ☐ Virtual ☐ In-person

Is the patient receiving any additional services? ☐ Yes ☐ No

If Yes, select services below (Please check all that apply):

☐ Mental Health Services
☐ Services Through the School System
☐ Occupational Therapy
☐ Physical Therapy
☐ Speech Therapy
☐ Primary Care (Pediatrician)
☐ Medication Management:
☐ Other Treatment: _____

Please indicate below which standardized assessment(s) were administered (or indicate page numbers in the treatment plan where this information can be found):

_____

_____

_____

Name of Assessment and Date of the Assignment:

Current Score: _____ Baseline Score: _____ Previous Score: _____

Form completed by:

_____
PRINT NAME TITLE

_____
SIGNATURE DATE (MM/DD/YYYY)