ABA APPROVAL REQUEST

Use this form for both initial and concurrent requests. Please indicate the type of request, as well as the type of services requested. Include the number of requested units as well as hours per day, and hours or days per week, as indicated. Please submit a complete treatment plan with this request. ****Note:** Per Plan guidelines, requests cannot be backdated.

Please fax this form and all applicable clinical documentation (plan of care for the member, clinical notes, etc.) to **717.346.5819**. Should you choose to use our standard ABA form, it can be found at: **CapBlueCross.com/wps/portal/cap/provider**:

Requested start date for this approval: _____

Requested for: ☐ Initial assessment ☐ Initial treatment ☐ Concurrent request

Patient's name: _____

Date of birth: _____ Age: _____ ☐ M ☐ F ☐ Other: _____

Phone number: _____ Patient's insurance ID#: _____

Additional insurance/COB: _____

Provider/Supervisor (BCBA, LBA, LABA, other)

Name: _____

ABA provider type: ☐ BCBA ☐ State licensed/certified Certification #: _____

State license #: _____ State: _____

NPI #: _____ Phone number: _____

Email address: _____

Provider group/agency: _____

TIN #: _____ NPI#: _____

Contracted with Capital Blue Cross: ☐ Yes ☐ No

Contracted with local Blue Cross: ☐ Yes ☐ No

Service address: _____

City/State/ZIP: _____

Phone number: _____ Email address: _____

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Patient's name: _____ ID# _____

SERVICES REQUESTED

(All units are 15-minute increments; 4 units equal 1 hour)

Program setting and hours per week:

☐ Home/Community _____ ☐ Facility/Clinic _____ ☐ Other: _____

Assessment/Follow-up assessment

By physician or other qualified health care professional (QHP). Behavioral identification assessment, administration of tests, detailed behavioral history, observation, caretaker interview, interpretation, discussion of findings, recommendations, preparation of report, development of treatment plan. Assessment of strengths and weaknesses of skill areas across skill domains (e.g., VB-MAPP, ABLLS-R, Functional Behavior Assessment, Functional Analysis) and follow-up assessments.

☐ **97151:** Behavior identification assessment (reassessment) administered by a physician/QHP. Units are in 15-minute increments, up to 32 units max for initial, up to 12 units max for reassessment.
Units requested: _____

☐ **97152:** Behavioral identification supporting assessment administered by technician under direction of physician/QHP, face-to-face with patient. Units are in 15-minute increments. **Clinical justification required.**
Units requested: _____

☐ **0362T:** Behavior identification supporting assessment for severe behaviors administered by a physician/QHP who is on-site, with the assistance of two or more technicians, for a patient who exhibits destructive behavior, completed in an environment that is customized to a patient's behavior. Units are in 15-minute increments. **Clinical justification required. Units requested: _____**

Direct 1:1 ABA Therapy

☐ **97153:** Adaptive behavior treatment by protocol administered by technician under the direction of physician/QHP, receiving 1 hour of supervision every 5 to 10 hours of direct treatment. Units are in 15-minute increments. **Hours per week: _____Units requested: _____**

☐ **97155:** Adaptive behavior treatment with protocol modification, administered by physician/QHP. May be used for **Direction of technician (supervision)** face-to-face with one patient. Unit are in 15-minute increments. **Hours per day: _____ Days per week: _____ Units requested: _____**

☐ **0373T:** Adaptive behavior treatment with protocol modification implements by physician/QHP who is on-site with the assistance of two or more technicians for severe maladaptive behaviors. Units are in 15-minute increments. **Clinical justification required. Hours per week: _____Units requested: _____**

Group adaptive behavior treatment

☐ **97154:** Group adaptive behavior treatment by protocol by technician under the direction of physician/QHP, face-to-face with two or more patients. Units are in 15-minute increments.
Hours per day: _____ Days per week: _____ Units requested: _____

☐ **97158:** Group adaptive behavior treatment with protocol modification **(Social Skills Group)** by physician/QHP, face-to-face with two or more patients. Units are in 15-minute increments.
Hours per day: _____ Days per week: _____ Units requested: _____

Family adaptive behavior treatment guidance (family training)

☐ **97156:** With individual family. Units are in 15-minute increments.
Hours per week: _____Units requested: _____

☐ **97157:** With multiple family group. Units are in 15-minute increments.
Hours per week: _____Units requested: _____