Capital

Patient's name: ____ ID # _______________________

APPLIED BEHAVIOR ANALYSIS (ABA)
Preauthorization Request Form
For Initial Assessment and Treatment

Please fax this completed form and all applicable clinical documentation to **717.346.5819.** An optional ABA progress report form can be located at: **Capital ABA Progress Report Form**.

Requested authorization start date:* *Note: Per plan guidelines, authorizations cannot be backdated.	**MM/DD/YYYY** / /
Type of request:	☐ Initial assessment (60 days). ☐ Initial treatment (6 months). ☐ Continued treatment (6 months).

Patient information		
Patient's name:	**Patient's ID #**	**Date of birth** MM/DD/YYYY / /
Diagnosis: **Date of most recent diagnostic evaluation:** **Evaluator's name and credentials:** **Is a copy of the most recent diagnostic evaluation attached?** ☐ Yes ☐ No		

Provider information		
Servicing provider group/ agency:	**TIN #:**	**NPI #:**
Service address:	**City/State/ZIP Code:**	**Phone number:** **Is VM confidential?** ☐ **Yes** ☐ **No**
Contracted with Capital Blue Cross: ☐ **Yes** ☐ **No** **Contracted with local Blue Cross:** ☐ **Yes** ☐ **No**		
Requesting provider/supervisor name:	**TIN #:**	**NPI #:**
ABA provider type: ☐ BCBA ☐ State licensed/certified	**Certification #:**	**State license #:** **Issuing state:**
Authorization specific contact name:	**Phone number:** **Is VM confidential?** ☐ **Yes** ☐ **No**	**Fax number:**

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SERVICES REQUESTED

Select the CPT codes that align with the services you are requesting and enter the number of hours requested and total number of units per authorization period. All units are 15-minute increments (four units equal one hour).

Please note: If hours on this form and hours in the treatment plan do not align, this form will be used as the official request.

Assessment codes:

☐ **97151**
_______ Hours per auth period
_______ Units per auth period

☐ **97152**
_______ Hours per auth period
_______ Units per auth period

☐ **0362T****
_______ Hours per auth period
_______ Units per auth period

Treatment codes:

☐ **97153**
_______ Hours per ☐ week ☐ month*
_______ Units per auth period

☐ **97154**
_______ Hours per ☐ week ☐ month*
_______ Units per auth period

☐ **97155**
_______ Hours per ☐ week ☐ month*
_______ Units per auth period

☐ **97156**
_______ Hours per ☐ week ☐ month*
_______ Units per auth period

☐ **97157**
_______ Hours per ☐ week ☐ month*
_______ Units per auth period

☐ **97158**
_______ Hours per ☐ week ☐ month*
_______ Units per auth period

☐ **0373T****
_______ Hours per ☐ week ☐ month*
_______ Units per auth period

***Month should only be chosen when the frequency of the service occurs at less than weekly intervals.**

****Requires specific clinical justification and supporting data.**

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Place of service							
Please select the location where the majority of services will be rendered. ☐ **Home** ☐ **Office (facility/clinic)** ☐ **School** ☐ **Community** ☐ **Other:**_______________________ **For initial and continued treatment requests, please specify anticipated service codes, place of service, and hours per location in the chart below:**							
Code	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
97153							
97154							
97155							
97156							
97157							
97158							
Other							

Please ensure that the following supporting documentation is included with your request *as applicable:*

- Comprehensive diagnostic evaluation completed by a qualified healthcare professional that confirms DSM diagnosis of autism spectrum disorder (ASD).
- Results from a reliable and valid standardized assessment that measures the patient's functioning in the domains included for diagnostic criteria for ASD, repeated every 6-12 months.
- Plan of services dated no more than 30 days prior to the requested start date to include:
  - Patient biopsychosocial Information.
  - Clearly defined and measurable skill acquisition, behavior reduction, and caregiver goals that have been identified to target specific behaviors and skills across all settings and environments where treatment will occur.
  - Quantifiable baseline, interim, and current data for all goals identified for treatment.
  - Results of functional behavioral assessment and description of function based antecedent and consequence interventions.
  - Plans for skill maintenance and generalization.
  - Individualized and realistic criteria for fading and discharge.
- Description of any barriers to providing this information and efforts to resolve those barriers.
- Any additional details to be considered for this request.

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