SUBMIT TO
Utilization Management Department
Phone 1-866-534-5976 | Fax 1-866-694-3649

absolute total care | Healthy Connections

Autism Spectrum Disorder (ASD) Authorization Form

MEMBER INFORMATION

Member Name: _____ Medicaid ID #: _____

Date of Birth: _____ Phone #: _____

Age: _____ Gender: ☐ Male ☐ Female

BILLING PROVIDER

Provider Name: _____ Tax ID: _____

Provider NPI: _____ Provider Address:_____

Contact Name: _____ _____

Phone #: _____ Fax #: _____

SUPERVISING PROVIDER

Provider Name: _____ Group/Facility Name: _____

Tax ID: _____ Provider NPI: _____

Provider Address: _____ Phone #: _____

_____ Fax #: _____

DIAGNOSTIC AND TREATMENT INFORMATION

Primary Diagnosis (Required): _____ Secondary: _____

Prior Treatment Relative to Diagnosis: _____

Standardized Tools Used for Diagnosis: _____

Diagnosis Date: _____ Is this Member in School? ☐ Yes ☐ No

Medical Conditions as Reported by Parent or Guardian: _____

List Prescribed Medications and Dosages: _____

Does the Member have an IEP or 504 Plan? ☐ Yes ☐ No Does the Member Receive Early Intervention Services? ☐ Yes ☐ No

Please Describe Other Services Received in Addition to the ABA Requested, Including but not Limited to, Physical Therapy, Occupational Therapy and Speech Therapy, or Mental Health Services: _____

_____

Is This an Intitial Request for Authorization? ☐ Yes ☐ No Date of ASD Treatment: _____

Date of Most Recent Reassessment: _____

AUTHORIZATION INFORMATION

Start Date: _____ End Date: _____

*Please note that prior authorization is required. Retrospective dates will not be processed. Please submit retrospective date requests to: 1-866-714-7991.

Code	Description	Time	Total Units Requested
☐ 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	
☐ 97162	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	

Please submit the information noted below with all treatment requests. If documentation is not received, the request will be reviewed based on the information available at the time of review.

For initial assessment, please submit: Comprehensive diagnostic information, including standardized measures and referral from diagnosing provider for Applied Behavioral Analysis services to include estimated duration of care.

For initial treatment plan please submit:

- Objective testing showing significant behavioral deficit.
- Description of coordination of services with other providers (e.g. school, PT, OT, ST).
- Proposed treatment schedule including the provider type who will render services.
- Proposed functional and measureable 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, 504, or IFSP if applicable.

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.

Supervising Provider Signature: _____ Date: _____

By signing above, I attest that I am actively participating in the treatment plan and coordinating services for the member.

Billing Provider Signature: _____ Date: _____

By signing above, I attest that all professionals and paraprofessionals rendering service under the proposed treatment plan have the appropriate training and education required to render services.