HIGHMARK HEALTH OPTIONS

Applied Behavioral Analysis (ABA) Prior Authorization Request Form

Complete and fax all requested information below including any supporting documentation as applicable to Highmark Health Options at **1-855-412-7997. Authorization is based on medical necessity.** Incomplete information or illegible forms will delay processing.

Include the following information for initial ABA requests:

1. Functional Behavioral Assessment: any psychosocial information, physical and behavioral health diagnosis, data driven informational tests, such as VB-APP or barrier.
2. Treatment plan and identified goals

Include the following information for continued stay requests:

1. Progress summary
2. Any changes or updates made to treatment plan or goals
3. Any updated assessments completed

Questions or concerns? Call Utilization Management at 1-844-325-6251 and follow the prompts to reach the Behavioral Health Utilization Management Team, Monday through Friday, 8 a.m. to 5 p.m.

Date: _____

Member Information		
Member Name	**Member ID**	**Date of Birth**
Diagnosis	**ICD-10 Code**	

Provider Information	
Facility Name	**NPI Number**
Facility Address	
Provider Name	**Provider NPI Number**
Provider Phone	**Provider Fax**
Contact Person Completing Form	**Contact Phone**
Contact Person at Facility	**Contact Fax**
Date of Admission or Start of Care Under Current Plan	
☐ **In-network Provider**	☐ **Out-of-Network Provider**
If Out-of-Network, does the member have a prior or existing treatment relationship with the provider? ☐ Yes ☐ No	

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Provide summary of member's treatment relationship with provider. Include why member's care cannot be met by an in-network provider.

Service Request	
Service Request	**Units Requested (use 1-hour increments; 1 unit=1 hour)**
97151	
97152	
97153	
97154	
97155	
97156	
97157	
97158	

Clinical Information
Describe presenting symptoms and problems.
List all diagnoses and conditions. Include diagnosis codes.

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Current Medications (Attach supplemental sheet if necessary)		
Medication	**Dosage**	**Frequency**

Current Case Management Needs
Describe current case management needs.

Discharge Planning and Transition to Lower Level of Care
Describe discharge planning and transition plan.
Can the member be managed at a lower level of care? ☐ Yes ☐ No **Provide justification.**