



Outpatient Behavioral Health (BH) – ABA Request Form

Send Fax Form and Supplemental Documents to: 1-877-650-6112

Please print clearly – incomplete or illegible forms may delay processing

Member Demographics	Diagnostic Information
Member's Name: _____	Primary Diagnosis: _____
Member's ID#: _____	Additional Diagnoses: _____
Date of Birth: _____	Diagnosed by whom: _____
Age: _____	Date of Diagnosis: _____
Authorization #: _____	
Provider Information	
Authorization Request: <input type="checkbox"/> Initial <input type="checkbox"/> Continued Stay Start Date for services: _____	
Servicing Facility Name: _____ NPI#: _____	
Par or Non-Par: _____	
Address: _____	
Phone #s: (____) _____ Fax#: (____) _____	
Servicing Provider Name: _____ NPI#: _____	
Primary Contact Name: _____ Phone #: _____	
Assessment and Treatment	
In addition to the information on this form, please attach: <ul style="list-style-type: none"> • Documentation of ASD diagnosis. • Full Behavioral Support Plan/Treatment Plan including the symptoms/behaviors requiring treatment, documentation of clinical team providing care including signature(s) of licensed supervising provider(s), and location (POS) of where services are provided. • Describe desired outcomes/alleviation of problems and/or symptoms in specific, behavioral, and measurable terms. • Diagnostic evaluation/report. 	
*Information older than 90 days will not be accepted for concurrent review.	



Considerations

Authorizations of care are subjected to a 6-month timeframe unless otherwise noted below

- Authorizations of care are subject to 12-month timeframe for Delaware member policies.

ABA requests are subject to medical policy. Please refer to Highmark policy: V-37 Autism Spectrum Disorders.

Please note that ABA services will not be authorized when they are primarily for educational purposes.

Services provided in the school are not eligible for Federal Employee Program (FEP) policies.

Adaptive Behavior Treatment	Units 15 mins/unit	CPT Code	Timeframe	Place of Service (POS)
Behavior Identification Assessment	_____	97151		school _____ other _____
Observational Behavioral Follow-Up Assessment	_____	97152		school _____ other _____
Adaptive Behavior Treatment by Protocol	_____	97153		school _____ other _____
Group Adaptive Behavior Treatment w/Protocol	_____	97154		school _____ other _____
Adaptive Behavior Treatment w/Protocol Modification	_____	97155		school _____ other _____
Family Adaptive Behavior Treatment Guidance	_____	97156		school _____ other _____
Multiple-Family Group Adaptive Behavior Treatment Guidance	_____	97157		school _____ other _____
Adaptive Behavior Treatment Social Skills Group	_____	97158		school _____ other _____
Exposure Behavioral Follow-Up Assessment	_____	0362T		school _____ other _____
Exposure Adaptive Behavior Treatment w/Protocol Modification (first 60 mins)	_____	0373T		school _____ other _____