



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: _____ Age: _____ Gender: M F	Diagnosed by whom: _____
Authorization #: _____	Date of Diagnosis: _____

Provider Information

Servicing Facility Name: _____ NPI #: _____

Par or Non-Par: _____

Address: _____

Phone #: (____) _____ Fax#: (____) _____

Servicing Provider Name: _____ NPI #: _____

Primary Contact Name: _____ Phone #: _____

Clinical Information

The patient's symptoms/mental status/clinical status select all that apply:

<input type="checkbox"/> Self-injurious behavior	<input type="checkbox"/> Poor social skills
<input type="checkbox"/> Destructive behavior	<input type="checkbox"/> Poor general development skills (ex. imitation, identifying objects, sharing skills)
<input type="checkbox"/> Aggressive behavior	<input type="checkbox"/> Self-stimulatory behavior
<input type="checkbox"/> Elopement	<input type="checkbox"/> Verbal outbursts
<input type="checkbox"/> Poor communication skills	<input type="checkbox"/> Other _____
<input type="checkbox"/> Tantrum behavior	

Current Medications: _____

Previous or current treatment within the past six months related to this patient's condition:

Assessment and Treatment

Standardized Assessment Tool used: _____

In addition to the information on this form, please attach:

- Full Behavioral Support Plan/Treatment Plan including the symptoms/behaviors requiring treatment (as indicated by the assessment tool)
 - Describe desired outcomes/alleviation of problems and/or symptoms in specific, behavioral and measurable terms
- Diagnostic evaluation/report

*Information older than 30 days will not be accepted for continued stay review



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Authorization Request: Initial Continued Stay Start Date of Plan of Care: _____

***Plan of care is subjected to a 6 month timeframe unless otherwise noted below**

Place of Service - School is not an approved/eligible POS for Federal Employee Program (FEP) policies

Adaptive Behavior Treatment	Units 15 mins/unit	CPT Code	Timeframe (180 days/ 26 weeks)	Place of Service (POS)
Behavior Identification Assessment		97151		
Observational Behavioral Follow-Up Assessment		97152		
Adaptive Behavior Treatment by Protocol		97153		
Group Adaptive Behavior Treatment w/Protocol		97154		
Adaptive Behavior Treatment w/Protocol Modification		97155		
Family Adaptive Behavior Treatment Guidance		97156		
Multiple-Family Group Adaptive Behavior Treatment Guidance		97157		
Adaptive Behavior Treatment Social Skills Group		97158		
Exposure Behavioral Follow-Up Assessment		0362T		
Exposure Adaptive Behavior Treatment w/Protocol Modification (first 60 mins)		0373T		

**Federal Employee Program (FEP) and Centene policies are not eligible for the below codes:*

Wraparound Services	Units 15 mins/unit	CPT Code	Timeframe (180 days/ 26 weeks)	Place of Service (POS)
Mental Health Service Plan Development by Non-Physician		H0032		
Therapeutic Behavioral Services, per 15 minutes		H2019		
Community-Based Wrap-Around Services, per 15 minutes		H2021		

Provider Signature

Date

License Information

My signature confirms that any paraprofessional under my supervision has the appropriate education and training.