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	_____
Authorization #: _____	Diagnosed by whom:_____
	Date of Diagnosis:_____

Provider Information

Servicing Facility Name:_____ NPI #:_____

Par or Non-Par:_____

Address:_____

Phone #s:__(___)_____ Fax#:_(_____)_____

Servicing Provider Name:_____ NPI #:_____

Primary Contact Name:_____ Phone #:_____

Clinical Information

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

☐ Self-injurious behavior
☐ Destructive behavior
☐ Aggressive behavior
☐ Elopement
☐ Poor communication skills
☐ Tantrum behavior
☐ Poor social skills
☐ Poor general development skills (ex. imitation, identifying objects, sharing skills)
☐ Self-stimulatory behavior
☐ Verbal outbursts
☐ Other _____

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.