

**Send Fax Form and Supplemental Documents to 1-833-581-1867**

Please print clearly – incomplete or illegible forms may delay processing

Member Demographics	Diagnostic Information		
Member's Name: _____ Member's ID#: _____ Date of Birth: _____ Age: _____ Gender: M F Authorization #: _____	Primary Diagnosis: _____ Additional Diagnoses: _____ _____ 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 selects all that apply: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Self-injurious behavior  <input type="checkbox"/> Destructive behavior  <input type="checkbox"/> Aggressive behavior  <input type="checkbox"/> Elopement  <input type="checkbox"/> Poor communication skills  <input type="checkbox"/> Tantrum behavior               </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Poor social skills  <input type="checkbox"/> Poor general development skills (ex. imitation, identifying objects, sharing skills)  <input type="checkbox"/> Self-stimulatory behavior  <input type="checkbox"/> Verbal outbursts  <input type="checkbox"/> Other _____               </td> </tr> </table> Current Medications: _____ Previous or current treatment within the past six months related to this patient's condition: _____		<input type="checkbox"/> Self-injurious behavior <input type="checkbox"/> Destructive behavior <input type="checkbox"/> Aggressive behavior <input type="checkbox"/> Elopement <input type="checkbox"/> Poor communication skills <input type="checkbox"/> Tantrum behavior	<input type="checkbox"/> Poor social skills <input type="checkbox"/> Poor general development skills (ex. imitation, identifying objects, sharing skills) <input type="checkbox"/> Self-stimulatory behavior <input type="checkbox"/> Verbal outbursts <input type="checkbox"/> Other _____
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Assessment and Treatment			
Standardized Assessment Tool used: _____ In addition to the information on this form, please attach: <ul style="list-style-type: none"> <li>• Full Behavioral Support Plan/Treatment Plan including the symptoms/behaviors requiring treatment (as indicated by the assessment tool)               <ul style="list-style-type: none"> <li>○ Describe desired outcomes/alleviation of problems and/or symptoms in specific, behavioral, and measurable terms</li> </ul> </li> <li>• Diagnostic evaluation/report</li> </ul> *Information older than 30 days will not be accepted for continued stay review			

**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*

<b>Adaptive Behavior Treatment</b>	<b>Units 15 mins/unit</b>	<b>CPT Code</b>	<b>Timeframe (180 days/ 26 weeks)</b>	<b>Place of Service (POS)</b>
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		

\_\_\_\_\_  
 Provider Signature Date

**License Information**

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