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 - <u>School</u> 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

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License Information

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