LOWER HUDSON VALLEY E.A.P

Mental Health & Substance Use Disorder Services

Applied Behavioral Analysis Authorization Request Form

Demographics		
Member name:		Member ID:
Date of birth:	Age:	Gender: ☐ M ☐ F
Diagnosis:		
Diagnosed by whom:		Diagnosis date:
Ordering physician		
Physician name:		Phone number:
Address:		
Agency information		
Agency name:		
Tax ID:	NPI:	
Are you in network:	☐ Yes ☐ No	
Phone number:	Fax number:	
Address:		
Contact person/phone:		
BCBA or rendering provider information		
Provider name:		
Tax ID:	NPI:	
Are you in network with members Insurance plan?	☐ Yes ☐ No	
Phone number:	Fax number:	
Address:		
Assessment and treatment		

For initial assessment requests, please attach one of the following:

- MD prescription recommending applied behavioral analysis (ABA)
- Recent comprehensive diagnostic evaluation completed by a physician or licensed psychologist
- Signed coordination of care letter recommending ABA by physician or licensed psychologist

Note: Treatment plan should be dated within 30 days of start date.

Please ensure the following have been included in your request:

Assessment and treatment (continued)
• A description of patient information, reason for referral, brief background information (e.g., demographics, living situation or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services. • Consider the member's age, school attendance requirements and other daily activities when determining the number of hours of medically necessary direct service and supervision. • Deliver BHT services in a home- or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school must be clinically indicated as well as proportioned to the total BHT services received at home and in the community. • Cumulative graphs/charts of baseline data and current progress. • Current behavioral support plan and treatment plan including symptoms and behaviors requiring treatment, skills to be addressed, baseline measures and current progress. • Describe desired outcomes/alleviation of problems and/or symptoms in specific, behavioral and measurable terms including updated evaluation of functioning via standardized tools at least every two years. • List any other services member is receiving (e.g., PT, OT, ST, school, behavioral health) and coordination of care with other providers. • Schedule of treatment (hours per day/week in each treatment setting — e.g., home, school, office). • Documentation of parental involvement and measurable parent goals. • Measurable client specific discharge criteria and transition plan.

Age of first ABA treatment:	**Start date of current request:**

Adaptive behavior treatment (per 15 min)	Units	CPT® code	Time frame
Behavior identification assessment		97151	Per authorization period*
Behavior identification supporting assessment		97152	Per authorization period*
Behavior identification supporting assessment, two or more technicians		0362T	Per authorization period*
Adaptive behavior treatment by protocol		97153	**Per week***
Group adaptive behavior treatment by protocol		97154	**Per week***
Adaptive behavior treatment w/protocol modification		97155	**Per month***
Family adaptive behavior treatment guidance		97156	**Per month***
Multiple-family group adaptive behavior treatment guidance		97157	**Per week***
Adaptive behavior treatment social skills group		97158	**Per week***

* Please note:

- Include UD modifier, if appropriate
- For 97151, 97152 and 0362T, list the # of units being requested for the entire authorization period.
- For 97155 and 97156, list the # of units being requested per month.
- For 97153, 97154, 97157, 97158 and 0373T, list the # of units being requested per week.
- Calculation used per week for 15-minute code: # of hours x 4 x 26 = total # of units for six-month/26-week authorization period.
- Calculation used per month for 15-minute code: # of hours x 4 x 6 = total # of units for six-month authorization period.

Provider name (print):	License information:
Provider signature:	Date:

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