Behavioral Health Service Request Form

Applied Behavior Analysis (ABA) For Autism Spectrum i

Medicaid
Please submit to the Dedicated Contract Fax Line: Nebraska – 1-855-279-3683

☐	**Standard Request**	Send requests for prior authorization (with supporting clinical information and documentation) to the Health Plan 14 days prior to the date the requested services will be performed.

Place of Service	☐ **11 - Office** ☐ **22 - Outpatient Hospital** ☐ **52- Psychiatric Facility-Partial Hospitalization** ☐ **53- Community Mental Health**

MEMBER INFORMATION					
Last Name		**First Name, Middle Initial**		**Date of Birth**	
Phone Number		**WellCare ID Number**		**Gender**	☐ **Male** ☐ **Female**
Third-Party Insurance	**Yes** **No**	If **Yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type, and number.		**Languages Spoken**	

TREATING PROVIDER/PRACTITIONER INFORMATION					
Last Name		**First Name**		**NPI Number**	
WellCare ID Number		**Participating**	☐ **Yes** **No**	**Discipline / Specialty**	
Street Address		**City, State**		**ZIP**	
Phone Number		**Fax Number**		**Office Contact**	

FACILITY/AGENCY INFORMATION					
Name		**Facility ID**		**NPI Number**	
Street Address		**City, State**		**ZIP**	
Phone Number		**Fax Number**		**Office Contact**	

BOARD CERTIFIED BEHAVIOR ANALYST INFORMATION				
For ABA services: Is provider certified to provide ABA-consistent services as defined by State's licensing requirements? **No** **Yes per State's licensing requirements**				
Have ABA services been ordered by a board-certified psychiatrist, psychologist or pediatrician qualified to provide ABA oversight? **No** **Yes; include copy of BCBA Order**				
Name of BCBA professional who will supervise services:		**BCBA certification #**		**Degree / License:**

Requested Services		
Service Type Requested	***List CPT Code(s)***	***Number of Units of Each CPT Code Requested***
Applied Behavior Analysis		

Service Request Start Date:

Behavioral Health Service Request Form

Applied Behavior Analysis (ABA) For Autism Spectrum i

Diagnosis Code and Description		
The following are mandatory fields. ABA service requests will not be processed if this section is not fully completed.		
Diagnostic	**When was the Autism Spectrum diagnosis established?** **Date:**	**By whom?** (***include full name and credentials***)
Diagnoses	☐ **Autism Spectrum Disorder** ☐ **With or** ☐ **without accompanying intellectual impairment** ☐ **With or** ☐ **without accompanying language impairment** ☐ **Associated with a known medical/genetic condition or environmental factor** (Coding note: Use additional code to identify the associated condition) ☐ **Associated with another neurodevelopmental, mental, or behavioral disorder** (Coding note: Use additional code[s] to identify the associated condition) ☐ **With catatonia** (Refer to the criteria for catatonia associated with another mental disorder)	**Co-occurring diagnoses, if applicable:** **Psychosocial Barrier if applicable:**
Diagnoses	**Primary** **Secondary** **Medical**	**Member who are <20 years old must have a diagnosis of one of the following:** • **Autism Spectrum Disorder** • **Asperger's Disorder (Asperger syndrome)** • **Pervasive developmental disorder not otherwise specified (PDD-NOS)** • **Childhood disintegrative disorder (CDD)** • **Rett's disorder (Rett syndrome)**

RATIONALE FOR REQUEST
Summary of functional capacities and areas of impairment
Assessment and clinical tool(s) used for diagnosis (e.g., BLA, Preference Assessment, FBA, ABLL S-R, VB-MAPP)
Biopsychosocial summary including household members, environmental factors and medical issues, current educational situation and school services
What type of treatment components will be provided?

TREATMENT PLAN	
Area of Concern #1	**(attach baseline level data for each area of concern)**
Behavior/Deficit to Decrease	
Behavior/Skill to Increase	
Methods to be used	
Goals and skills of parent/guardian	
Objective criteria for attainment of goal	