# Applied Behavior Analysis (ABA) Prior Authorization Form

In the hope to save you, our provider, some time on the phone, we invite you to fill out this form for ABA treatment requests. In filling out this form, you are doing so in lieu of the telephonic clinical review. This form should be completed by a provider who has a thorough knowledge of the Evernorth customer's current clinical presentation and treatment history. *Please note: The information contained in this form may be released to the customer or the customer's representative.*

This form is based on our coverage policy for Intensive Behavioral Interventions and can be found:
https://static.evernorth.com/assets/chcp/resourceLibrary/coveragePolicies/medical_a-z.html

**TIPS FOR COMPLETING THIS FORM:**

- Our regular business hours are Monday – Friday, from 7:30am – 5:00pm Central Time
- To help expedite this request, please complete sections as **specifically** and as **clearly** as possible. Omissions, generalities, and illegibility may result in this request being returned for additional information or clarification.
- Typed responses are preferred. If completing by hand, please use blue or black ink and print legibly.
  - If treatment plan is referenced for response, please indicate page number.
- Please note ABA assessment codes (97151, 97152, 0362T) no longer require preauthorization unless requesting a network exception. If you are requesting a Network Exception, please fill out our Network Exception request for initial ABA Assessment.
- Please ensure to always submit the most updated forms, which are accessible by visiting the Evernorth Provider website (Provider.Evernorth.com) > Resources > Forms Center > Behavioral Health Forms.

**Please save this form to your computer, complete & save the form using Adobe Acrobat Reader DC, then email it to:**
**ABA@Evernorth.com*** **(preferred)** or fax 1.860.687.9230

* Please note that Evernorth assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information. It is your responsibility to take any steps necessary to protect the email or documents prior to receipt by Evernorth.

**All fields are required.**

| Customer Information | | |
|---|---|---|
| **Customer Name:** | **Member ID:** | **Date of Birth** MM / DD / YYYY |
| **Address:** | | |
| **Customer/Caregiver Contact Information:** | | |
| **Is the customer diagnosed with Autism Spectrum Disorder (ASD):** ☐ Yes ☐ No<br>**Date of most current diagnostic evaluation and evaluator's name/credentials:** | | |
| **Please list any additional diagnosis (please include diagnosis and diagnostic code).** | | |

| Provider Information | | |
|---|---|---|
| **Supervising Provider's Name:** | **Tax ID:** | |
| **Email Address:** | **Phone Number:** (   ) | **Is Voicemail confidential?** ☐ Yes ☐ No |
| **Is the provider above providing all supervision for the customer's ABA case?**<br>☐ Yes ☐ **No - If No, please list who else is providing supervision and their credentials.** | | |

**Please check what applies. The supervising provider is credentialed or licensed as:**

☐ BCBA ☐ BCBA-D ☐ LBA ☐ Licensed Psychologist

☐ Other Licensed (Please specify)

**Clinic Name:**

**Clinic Contact (if different from provider):**

**Clinic/Practice Address:**

**Please indicate level of benefit requested:**

☐ I am an in-network provider with Evernorth and requesting an in-network authorization

☐ I am an out of network provider with Evernorth and requesting an out of network authorization

☐ I am an out of network provider and I am requesting an in-network exception. If yes, please answer A and B:

A.) How many assessment units are you requesting during the auth period:
97151: _____ units | 97152: _____ units | 0362T: _____ units

B.) What specialized experience, training or certification in a particular clinical area or patient population do you poses that would support the need for an in network exception request?

**Please indicate if authorization is requested to the supervising provider or clinic:**

**Please list the best times our team could contact you within the next five business days for questions, concerns, or determination information:**

## Treatment History and Coordination of Care

**ABA**

**How long has the customer been receiving ABA treatment from your agency:**

**Has there been any gaps in care or changes in supervising provider since last request?** ☐ Yes ☐ No
**If Yes, please provide information below:**

**Other Treatment**

**Is the customer receiving any additional services?** ☐ Yes ☐ No If Yes, (check all that apply)

☐ Speech Therapy ☐ Mental Health Services ☐ Primary Care (Pediatrician)

☐ Occupational Therapy ☐ Physical Therapy ☐ Services through the school system

☐ Prescribing Physician *(note medications below)* ☐ Other: ____________

**Do you collaborate with all of the providers above?** ☐ Yes ☐ No ☐ Plan to collaborate very soon

**If no, please explain why:**

## Standardized Assessment

**Please indicate which standardized assessment(s) were administered (or indicate page numbers in the documents submitted):**

1. **Name of Assessment:** ____________________
   a. **Current Score:** ____________________ **Date:** __________
   b. **Previous Score:** ____________________ **Date:** __________
   c. **Baseline Score:** ____________________ **Date:** __________
2. **Name of Assessment:** ____________________
   a. **Current Score:** ____________________ **Date:** __________
   b. **Previous Score:** ____________________ **Date:** __________
   c. **Baseline Score:** ____________________ **Date:** __________

**If additional assessments were used, please include the assessment, dates of administration, and scores**

## Current ABA Treatment Information

**Place(s) of Service (i.e. Home, Clinic, etc.)**

**Please attach clinical information to show that an individualized treatment plan has been developed. This should include specific targeted behaviors/skills for improvement, along with clearly defined, measurable, and realistic goals for improving those behaviors/skills and addresses the all of the information below.**

**I have included information to address the following in the attached ____* pages of clinical information** *(check all that apply).*

- ☐ Treatment goals are directly related to the symptoms of ASD as defined by the current edition of the DSM
- ☐ Baseline, interim and current data are reported for all goals.
- ☐ The treatment plan includes a measurable parent/caregiver (including teachers and other stakeholders as appropriate) goals to train them in the basic behavioral principles of ABA and to continue behavioral interventions in the home and community with data to demonstrate parent progress with those goals.
- ☐ The treatment plan includes a plan to ensure maintenance and generalization of skills.
- ☐ There are clearly defined, measureable, and realistic discharge criteria that are individualized to the customer.

**If any boxes are not checked above, please add information as to why:**

*** Please indicate how many pages you are attaching, not including this form.**

## Current Requested Treatment

**We encourage you to make any requests for services no earlier than 2-4 weeks prior to the requested start date. This will ensure we have the most up to date clinical information.**

**Start date for current authorization request:** ______________

| BCBA/Supervisor Hours | | | |
|---|---|---|---|
| **Code** | **Hours** | **Units** | **Time Frame** |
| 97155* | | | Per month |
| 97156 | | | Per month |
| 97157 | | | Per month |
| 97158 | | | Per month |
| 0373T | | | Per month |

| Technician/RBT Hours | | | |
|---|---|---|---|
| **Code** | **Hours** | **Units** | **Time Frame** |
| 97153 | | | Per month |
| 97154 | | | Per month |

***Are any of the 97155 units used for 1 to 1 direct care with the customer?** ☐ **Yes** ☐ **No**

**If Yes, how many?**

| Hours | Units | Time Frame |
|---|---|---|
| | | Per month |

**If the above is not the same as what was approved at the last authorization review, please indicate the specific change in units/hours and the clinical rationale.**

______________________________________________________________________

**Supervisor's Signature/E-Signature:** ______________________________________________

**Date:** ______________

**Please Note: The information on this form and attached clinical is what will be used in making a determination. The hours/units listed above will be considered the official hour/unit request**

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