Phone: 602- 263-3000 or 800-624-3879
Fax: 800-217-9345

Applied Behavior Analysis (ABA) Services Prior Authorization Request Form

Request completed by: _____ Phone #: _____ Fax #: _____
Date of Request: _____ Total Number of Pages: _____
Authorization on File (check one): Yes☐ No ☐ If Yes, Date of Last Scheduled Visit: _____
Is the member diagnosed with Autism Spectrum Disorder (ASD) (check one) – F84.0? Yes ☐ No ☐

- If not, what is the current diagnosis code(s): _____

Member Information
Member Name: _____ Member ID #: _____ DOB: _____
Other Insurance(check one):Yes☐ No☐ If yes please specify: _____
Phone #: _____

Behavioral Health Home
Provider Name: _____
Address: _____
Phone #: _____ Fax #: _____
Member receiving High Needs Case Management(check one): Yes☐ No☐
Contact Name and Phone #: _____

Rendering Service Provider Information
Provider Name: _____ TIN/NPI#: _____
Address: _____
Phone #: _____ Fax #: _____

Credentials for provider delivering clinical direction and supervision:
☐BCBA ☐BCBA-D ☐LBA ☐ Behavior Health Professional ☐Other (specify): _____

Assessment & Treatment
ABA Therapy being requested (**required**)(check one): ☐ Focused or ☐ Comprehensive
Please ensure the following has been included in your request:

- Assessment findings:
  a. Brief description of assessments, including their purpose;
     - Indirect Assessments: Summary of findings for each assessment (graphs, tables, or grids);
     - Direct Assessments: Summary of findings for each assessment (graphs, tables or grids);
  b. Target behaviors are operationally defined, including baseline levels;
  c. Functional Behavior Assessment, if applicable.
- Individualized Treatment plan should include the following:
  - Treatment setting and modality by which service will be delivered (in-person, via telehealth, group, individualized setting, or combination thereof);
  - Operational definition of each behavior/goal/skill;

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- Data collection procedures;
- Behavior management/treatment protocols;
- Treatment goals and objectives;
- Parent/caregiver training procedures and goals/objectives;
- Plan to ensure maintenance and generalization of skills;
- Care coordination activities;
- Discharge criteria clearly defined and measurable.

Standard Assessment Information (required)

** On re-authorization, must complete a re-assessment every 6 months*

- Type of Assessment completed: _____
- Current Score: _____ Date: _____

- Type of Assessment completed: _____
- Current Score: _____ Date: _____

- Type of Assessment completed: _____
- Current Score: _____ Date: _____

CPT and Hours of Supervision and Therapy

The following timeframes are needed to report to AHCCCS:

- Hours of direct therapy for entire authorization timeframe: _____
- Hours of supervision provided for entire authorization timeframe: _____

CPT Code(s):

Example for Therapy & Supervision for 6 months

CPT	Purpose: Direct Therapy or Supervision	Hours Per Week	Units Per Week	Timeframe in weeks	Total units
97153	Therapy	40 hours week	160 week	24 weeks	3,840
97155	Supervision	12 hours week	48 week	24 weeks	1,152

*Purpose: Due to reporting requirements, enter separate line to distinguish supervision vs therapy.

PROVIDER TO FILL IN FOR ALL CPT codes

CPT	Purpose: Direct Therapy or Supervision	Hours Per Week	Units Per Week	Timeframe in weeks	Total Units
97153	Supervision				
97153	Therapy				
97154	Therapy				
97155	Supervision				
97155	Therapy				
97156	Therapy				
97157	Therapy				
97158	Therapy				