



## Applied Behavior Analysis (ABA) Services Prior Authorization Request Form

<p>*1. Date of Request: _____</p> <p>*2. Requested Dates of Service: _____ - _____</p> <p>*3. Request change to a previous PA: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Previous PA# _____</p> <p>*4. Will remote access technology be used? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>*5. Will restrictive interventions be used? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><b><u>FAX THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO</u></b></p> <p><b>(801) 536-0147</b></p> <p>OR MAIL TO:          UTAH MEDICAID PRIOR AUTHORIZATION UNIT          PO BOX 143111          SALT LAKE CITY, UT 84114-3111          FOR QUESTIONS REGARDING PRIOR AUTHORIZATIONS , PLEASE CALL:          (801) 538-6155 OPTIONS 3, 3, 7</p>		
<b>Member Information</b>			
*6. Member Name	*7. Member ID#		
*8. Date of Birth	*9. Age	*10. Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	
<b>Requesting/Referring Provider Information</b>			
*11. Provider Name	*12. Provider NPI #		
*13. Provider Address _____ _____	*14. Provider Phone Number ( ) _____ Ext. _____ Office Contact Name _____	*15. Provider Fax Number ( ) _____	
<b>Servicing Provider Information (if different than Requesting Provider)</b>			
16. Provider Name	17. Provider NPI #		
18. Provider Address _____ _____	19. Provider Phone Number ( ) _____ Ext. _____ Office Contact Name _____	20. Provider Fax Number ( ) _____	
<b>*Requested Service(s)</b>			
Initial Assessment	Total Units Requested		
<input type="checkbox"/> 0359T Behavior Identification Assessment			
<input type="checkbox"/> 0360T Functional Assessment			
Therapy Service	Requested Hours Per Day	Requested Days Per Week	Total Units
<input type="checkbox"/> 0364T Adaptive Behavior Treatment (30 min)			
<input type="checkbox"/> 0366T Group Adaptive Behavior Treatment (30 min)			
<input type="checkbox"/> 0368T Adaptive Behavior Treatment with Protocol Modification (30 min)			
<input type="checkbox"/> 0370T Family Adaptive Behavior Treatment Guidance			
<input type="checkbox"/> 0371T Multiple-Family Group Adaptive Behavior Treatment Guidance			
<input type="checkbox"/> 0372T Adaptive Behavior Treatment Social Skills Group			
<b>*CERTIFICATION OF MEDICAL NECESSITY</b>			
I certify that all services requested are medically necessary and appropriate for this patient.			
_____ First and Last Name			



## Applied Behavior Analysis (ABA) Services Prior Authorization Request Form

### INSTRUCTIONS FOR PRIOR AUTHORIZATION REQUEST FORM

**\*ALL BOLDED INFORMATION BELOW MUST BE COMPLETED LEGIBLY AND CORRECT OR THE REQUEST WILL BE RETURNED WITHOUT BEING PROCESSED\***

1. **Date of request**
2. **Requested dates of service**
3. **Request change to a current prior authorization** (If yes, please provide the current PA #)
4. **Will remote access technology be used?**
5. **Will restrictive interventions be used?** (If yes, provide the treatment plan that describes the use of the interventions and the clinical oversight that will protect the individual from misuse)
6. **Member Name**
7. **Member ID#** (Enter the entire 10 digit Medicaid Identification Number of recipient)
8. **Date of Birth**
9. **Age**
10. **Gender**
11. **Requesting/Referring Provider Name**
12. **Requesting/Referring Provider NPI #**
13. **Requesting/Referring Provider Address**
14. **Requesting/Referring Provider Phone Number** (include office contact name)
15. **Requesting/Referring Provider Fax Number**
16. **Servicing Provider Name** (ALL Servicing Provider information is required if different from Requesting Provider)
17. **Servicing Provider NPI #**
18. **Servicing Provider Address**
19. **Servicing Provider Phone Number** (include office contact name)
20. **Servicing Provider Fax Number**
21. **Requested Service(s)** At least one service must be selected. Include hours per day, days per week and total units for 0364T, 0366T and 0368T. All other codes only require the total units being requested.
22. **Certification of Medical Necessity**

**FAX THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO:**

(801) 536-0147

OR MAIL TO:

UTAH MEDICAID PRIOR AUTHORIZATION UNIT

PO BOX 143111

SALT LAKE CITY, UT 84114-3111

FOR QUESTIONS REGARDING PRIOR AUTHORIZATIONS, PLEASE CALL: (801) 538-6155 OPTIONS 3, 3, 7