



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

<p>*1. Date of request: _____</p> <p>*2. Requested dates of service: _____ - _____</p> <p>*3. Is this request a change to a previous PA? <input type="checkbox"/> No <input type="checkbox"/> Yes    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>*6. Is this a retroactive request? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list reason in the "additional information" section below)</p> <p>*7. Does the patient have primary insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of last insurance verification: _____</p> <p>*8. Is ABA therapy covered under primary insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>*9. For members with other ABA coverage, are you a covered provider under the primary insurance plan? <input type="checkbox"/> No <input type="checkbox"/> Yes (If no, please provide details in the "additional information" section below)</p>	<p><b><u>SUBMIT THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO:</u></b></p> <p><b>FAX:</b> (801) 536-0147</p> <p>OR</p> <p><b>EMAIL:</b> fax_autismservices_prior@utah.gov <b>*(email must be sent encrypted)</b></p> <p>OR</p> <p><b>MAIL TO:</b></p> <p>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>	
*10. Member Name	*11. Member ID#
*12. Date of Birth	*13. Age
*14. Gender                      Male <input type="checkbox"/> Female <input type="checkbox"/>	
<b>Additional Information</b>	
<b>Provider Information</b>	
*15. Provider Name	*16. Provider NPI #
*17. Provider Address	*18. Provider Phone Number
_____	(____) _____ Ext. _____
_____	Office Contact Name
_____	_____
	19. Provider Fax Number
	(____) _____
	20. Provider Email Address
	_____
<b>*22. Requested Service(s)</b>	
<b>Assessment</b>	
<input type="checkbox"/> 97151 Behavior Identification Assessment	
<input type="checkbox"/> 97151 Functional Assessment	
<b>Therapy Service</b>	<b>Requested Units Per Week</b>
<b>Total Units for 26 Week Authorization Period</b>	
<input type="checkbox"/> 97153 Adaptive Behavior Treatment (per 15 min)	
<input type="checkbox"/> 97154 Group Adaptive Behavior Treatment (per 15 min)	
<input type="checkbox"/> 97155 Adaptive Behavior Treatment with Protocol Modification (per 15 min)	
<input type="checkbox"/> 97156 Family Adaptive Behavior Treatment Guidance (per 15 min)	
<input type="checkbox"/> 97157 Multiple-Family Group Adaptive Behavior Treatment Guidance (per 15 min)	
<input type="checkbox"/> 97158 Adaptive Behavior Treatment Social Skills Group (per 15 min)	



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### INSTRUCTIONS FOR PRIOR AUTHORIZATION REQUEST FORM

**\*ALL BOLDDED 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. **Is this request a 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. **Is this a retroactive request?** (Provide justification for requesting services retroactively in the section "additional information")
7. **Does the patient have primary insurance?** (Must include the last verification date)
8. **Is ABA therapy covered under the primary insurance plan?**
9. **For members with other insurance, are you a covered provider under the primary insurance plan?** (Please see the Autism Service Provider Manual for required insurance documentation)
10. **Member Name**
11. **Member ID#** (Enter the entire 10 digit Medicaid Identification Number of recipient)
12. **Date of Birth**
13. **Age**
14. **Gender**
15. **Provider Name**
16. **Provider NPI #**
17. **Provider Address**
18. **Provider Phone Number (Include office contact name)**
19. **Provider Fax Number** (Either a fax number or email address must be provided)
20. **Provider Email Address** (Either a fax number or email address must be provided)
21. **Requested Service(s)** If requesting a change in services from a previous prior authorization, only include the additional units that need authorization. Do not include the previously authorized units.

Please refer to the Utah Medicaid Provider Manuals for more detailed information

[AUTISM SPECTRUM DISORDER RELATED SERVICES FOR EPSDT ELIGIBLE INDIVIDUALS  
SECTION I-GENERAL INFORMATION](#)