ABA AUTHORIZATION REQUEST

*Use this form for both initial and concurrent **Medi-Cal** requests. Please indicate the type of request, as well as the type of services requested. Include the number of requested units as well as hours per day, and hours or days per week, as indicated. Please submit a complete treatment plan with this request.*

Requested Start Date for this Authorization: _____

Request for:

❑ Initial Assessment ❑ Initial Treatment ❑ Concurrent Request

Patient's Name: _____

Date of Birth: _____ Age: _____ ❑ M ❑ F ❑ Other: _____

Phone Number: _____ Patient's Insurance ID#: _____

Patient's Employer/Benefit Plan: _____

Provider/Supervisor (BCBA, LBA, LABA, other)

Name: _____

ABA Provider Type: ❑ BCBA ❑ State Licensed/Certified

Certification/License #: _____ State: _____

NPI #: _____Provider ID (if known)

Phone Number: _____

Email address: _____

Provider Group/Agency: _____

TIN #: _____ Provider Group ID # (if known): _____

Service Address: _____

City/State/Zip: _____

Phone Number: _____

Email address: _____

SERVICES REQUESTED

(All units are 15 minutes; 4 units equal 1 hour)

Program setting and hours per week:

❑ Home _____ ❑ Facility/Clinic _____ ❑ School _____ ❑ Other: _____

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Patient's Name: _____ **ID#:** _____

Assessment / Follow-up Assessment:

By BCBA. Behavior identification assessment, administration of tests, detailed behavioral history, observation, caretaker interview, interpretation, discussion of findings, recommendations, preparation of report, development of treatment plan. Assessment of strengths and weaknesses of skill areas across skill domains (e.g., VB-MAPP, ABLLS-R, Functional Behavior Assessment, Functional Analysis and/or Vineland).

❑ **H0031:** Behavior identification assessment (initial) administered by a physician/QHP. Units are in 15-minute increments; up to 32 units max.

Units Requested: _____

Treatment Planning/Re-assessment:

❑ **H0032:** Treatment planning/Reassessment by a BCBA. Units are in 15-minute increments, up to 32 units per authorization period unless MNC rationale provided for additional units.

Units Requested for Authorization Period: _____

Direct 1:1 ABA Therapy

❑ **H2019:** Adaptive behavior treatment by protocol administered by technician under the direction of BCBA/BCaBA/QAS. Units are in 15-minute increments.

Hours per week: _____ **Units Requested:** _____

❑ **H2012:** Adaptive behavior treatment with protocol modification, administered by BCBA/BCaBA/QAS (25% of supervision must be delivered by a BCBA). May be used for **Direction of Technician (Supervision)** face-to-face with one patient. Units are in 15-minute increments.

Hours per week: _____ **Units Requested:** _____

Group Adaptive Behavior/Social Skills Treatment

❑ **H0014:** Group adaptive behavior treatment with protocol modification **(Social Skills Group)** by BCAB/BCaBA/QAS/MFT/LCSW/Licensed Professional**,** face-to-face with two or more patients. Units are in 15-minute increments.

Hours per week: _____ **Units Requested:**_____

Family Adaptive Behavior Treatment Guidance (Family Training)

S5111: Parent(s)/guardian(s) training by BCBA/BCaBA/QAS, with or without the patient present Units are in 15-minute increments.

Hours per month: _____ **Units Requested:** _____