coordinated care™

SUBMIT TO
Coordinated Care
Utilization Management Department
1145 Broadway, Suite 300
Tacoma, WA 98402
PHONE: 1.877.644.4613
FAX: 1.833.286.1086

APPLIED BEHAVIORAL ANALYSIS PRIOR AUTHORIZATION REQUEST FORM

Please print clearly and fill out entire form even if the information is documented in attachments.
Incomplete or illegible forms will be returned. ***Required Fields**

*Date: _____

*Patient Information

*Name _____

*Date of Birth _____

*Patient Medicaid Number _____

*Provider Information / Billing Facility

*Provider Name _____

*Facility Name _____

*Individual/Facility NPI _____

*TIN# _____

*Authorized Specific Contact Person _____

*Claims will be under:

☐ Provider ☐ Facility

Phone _____

*Fax _____

*Services Requested

Procedure Code: _____ Start Date _____ End Date _____

Units Requested: _____

Procedure Code: _____ Start Date _____ End Date _____

Units Requested: _____

Procedure Code: _____ Start Date _____ End Date _____

Units Requested: _____

*ICD 10 Diagnosis Code(s)

Primary: _____ Secondary: _____ Additional: _____

*Current Medications (name and dosage)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

All Medical Conditions as reported by parent/guardian:

_____

_____

_____

Coordination of Care:

Coordinated has occurred with:

PCP ☐ yes ☐ no Psychiatrist ☐ yes ☐ no

Name of PCP: _____ Name of Psychiatrist: _____

Current or historical behavioral health treatment: ☐ yes ☐ no

Name of Treating Behavioral Health (BH) Provider: _____

Has ABA treatment been reviewed with BH provider: ☐ yes ☐ no

Parent/guardian agrees with ABA treatment goals: ☐ yes ☐ no

***Initial/1st ABA: In order to process the authorization it is required to have all documents attached. Check box indicating what is attached:** (the request must be received 5 days before the requested start date.)

☐ Initial Evaluation

☐ Treatment Plan with Smart Goals

Documentation must include: Projection of evolution, assessment instruments, developmental markers and readiness, evidence of coordination with provider.

☐ Signed copy of prescription for ABA Therapy Services

☐ The DSM- 5 check list

☐ ABA Level of support Requirements form HCA 12-411

***Recertification of ABA Services: In order to process the authorization it is required to have all documents attached. Check box indicating what is attached:** (please request at least **three weeks** before current uthorization expires)

☐ Current Evaluation/ Assessment

☐ Current Treatment Plan with Smart Goals

Documentation must include: Measureable changes in frequency, intensity, and duration of the targeted behaviors or symptoms addressed in previous authorization. Including: Projection of evolution, assessment instruments, developmental markers and readiness, evidence of coordination with provider.

☐ Current Level of Support

Information older than 30 days will **not** be accepted for recertification of ABA Services