APPLIED BEHAVIOR ANALYSIS (ABA)

INITIAL PRIOR AUTHORIZATION REQUEST

(This form must be filled out completely or your request will be considered as incomplete, will receive a technical denial, and will require resubmission)

Request type:	Initial
Date of request:	

Provider Name:	Provider ID w/Service Loc:

Treating BCBA email address:	BCBA phone number:
Name of BCBA:	Member ID:
Primary clinic email address:	Primary clinic phone number:
Member name:	Member age and DOB:
Date of Comprehensive Diagnostic evaluation/assessment/provider:	Custodial agency (i.e., DHS, OJA, N/A):
(Comprehensive assessment must be completed prior to start of services and copy included with this request)	Custody status (temporary, permanent, no involvement with state custody):

Will ABA treatment service be provided in-person via telehealth or hybrid by the BCBA?	How often will the BCBA provide services via telehealth? How often will the BCBA provide services in person?
How often will the treating BCBA provide 1:1 in person supervision of the treating RBT(s) (cpt code 97155)? What is the duration of time supervision will be provided for this review period?	How often will the treating BCBA provide 1:1 telehealth supervision of the treating RBT(s) (cpt code 97155)? What is the duration of time supervision will be provided for this review period?
Please identify the RBT(s) and/or BCaBA(s) that will work with the member. (Note: OHCA understands this may change through the authorization period.)	Date member will start ABA services:

OKLAHOMA
Health Care Authority

Estimated duration of ABA services based on current deficits/maladaptive behaviors (planned time from initiation of care to completion, in months:

Requested Start Date:	Requested End Date (date cannot exceed 6 months per authorization period)	Hours requested per week for each CPT code:	Frequency requested (i.e., high, moderate, targeted, maintenance):

DSM-5 diagnoses with accompanying specifiers (e.g., 299.00 autism spectrum disorder). The primary diagnosis must be ASD-related.

Diagnoses:
Primary Diagnosis Code:
Diagnosis Description:
Diagnosis Code:
Diagnosis Description:

Does the member have a primary insurance? If so, please identify the primary insurance information. Does the primary insurance cover ABA? If so, please provide prior authorization letter of hours approved or showing ABA is not a covered benefit?
Is member transitioning back from a managed care entity (i.e., Aetna, Humana, Oklahoma Complete Health)? If so, please attach a copy of the prior authorization letter showing dates and hours of previous approval.

Is member transitioning back from a managed care entity (i.e., Aetna, Humana, Oklahoma Complete Health)? If so, please attach a copy of the prior authorization letter showing dates and hours of previous approval.
List the guardian's name and relationship to member including their address and phone number. If DHS/OJA involvement, list caseworker contact info including email address.
Has a comprehensive diagnostic evaluation/clinical assessment been completed? If yes, please provide a copy with this request. This must be completed prior to start of services.
Does the member currently or have they previously received ABA services? Please list the recommended treatment hours per week. The expectation is for the parent/legal guardian to attend and participate in sessions with the member, as set forth by the treatment provider on the treatment plan.

Does the member have any other treatment services (i.e., OT, PT, speech, BH outpatient counseling, school-based services via an IEP)? If so, please list them below, including the days and times.
Is this prior authorization request for school-based services? **(Note: ABA is not reimbursable by Medicaid in a school setting and is only approved on a time limited basis when a member is transitioning from clinic back to school or from an inpatient stay.)**
If member attends school, what days and times? What days and times does member attend ABA treatment?

Targeted Behaviors for Reduction

Describe the member's maladaptive behavior/deficits, atypical or disruptive behaviors exhibited within the last 30 days that interfere with daily functioning or pose a potentially dangerous risk to the member as seen from direct observation or parent report (e.g., aggression, self-injurious behavior, PICA, excessive self-stimulation, severe disruption in daily functioning, core deficits of ASD).
Please document the member's most current maladaptive behavior/deficits, atypical or disruptive behaviors within the last 14 days, provide specific dates and times from direct observation or parent report (e.g., what led up to the incidents, what interventions were attempted and were they successful or did they fail, how long did the member's episode of disruptive behavior last. (Note: To be completed for high & moderate frequency prior authorization request.)
What is the primary focus of treatment for the behaviors described above? (Treatment plan goals should identify the core deficits of ASD or maladaptive behaviors being treated.)