SmartHealth

Applied Behavior Analysis (ABA) Therapy Request Form

To process your request without delays, this form must be completely filled out and ***necessary documentation attached.*** Fax all requests to **586-693-4768. Requests must be prior to services and will not be reviewed retroactively.**

Patient Information	**Provider Information**	
Today's Date:	Provider Name:	
Member Name:	TIN and NPI:	
Member's ID#:	Office Contact Person:	
Date of Birth:	Office Phone:	Office Fax:

Required Information

Has a diagnosis of Autism/Autism Spectrum Disorder been established? Yes No	Year diagnosis established:	Is documentation of diagnosis attached? Yes No	ICD-10 Diagnosis Code (F84.0):

How long has the member received ABA services?

SmartHealth requires documentation of an autism diagnosis established by autism testing before authorizing the evaluation and treatment planning. It must be included with the request and must be dated within three years of request.

Initial Request for Service or Indicate when service was completed prior to 2024 - 90 day maximum

**** You can only request for 6 months after you have received (2) previous 90 days approved****

Date(s) of Service:

□Behavior identification assessment…by physician (97151), per 15 min.	# of units in 90 days	# of units in 6 months
□Behavior identification supporting assessment…by technician (97152), per 15 min.	# of units in 90 days	# of units in 6 months
□Behavior identification supporting assessment…by physician on site (0362T), per 15 min.	# of units in 90 days	# of units in 6 months

Request for Treatment and/or Extension of Services - 90 day maximum ** You can only request for 6 months after you have received (2) previous 90 days approved **

Previous Authorization #	Date(s) of Service:	
□Adaptive behavior treatment by protocol…by technician (97153), per 15 min.	Total # of units in 90 days	**Total # of units in 6 months
□Adaptive behavior treatment with protocol modification…by physician on site (0373T), per 15 min.	Total # of units in 90 days	**Total # of units in 6 months
□Adaptive behavior treatment with protocol modification…by physician (97155), per 15 min.	Total # of units in 90 days	**Total # of units in 6 Months
□Group adaptive behavior treatment by protocol…by technician (97154), per 15 min.	Total # of units in 90 days	**Total # of units in 6 months
□Group adaptive behavior treatment with protocol modification…by physician (97158), per 15 min.	Total # of units in 90 days	**Total # of units in 6 months
□Family adaptive behavior treatment guidance…by physician (97156), per 15 min.	Total # of units in 90 days	**Total # of units in 6 months
□Multiple-family group adaptive behavior treatment guidance…by physician (97157), per 15 min	**Total # of units in 90 days	**Total # of units in 6 months

Are any of these units performed in a school setting? If so, which ones and how many?

You are only eligible to request for a 6 months treatment after you have already been approved for (2) previous 90 day approvals. If you submit for 6 months but not eligible your request will be returned and will have to be resubmitted.

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If the requested hours are not the same as what was approved at the last review, please indicate the specific clinical rationale for the change:

Who is supervising/directing the ABA services? (name,credential/certification, and phone number)

Is the member receiving any additional services? Yes / No. If Yes, (Circle all that apply) Physical Therapy, Occupational Therapy, Speech Therapy, Mental Health Services, Primary Care Physician Services through the school system.

Prescribing Physician: If so, Medications:
Other:
Do you collaborate with all the providers above? Yes / No If no, please explain why:

3. Check box to ensure the following essential elements are met

☐ Diagnosis of Autism Disorder	☐ Coordination with supplemental resources
☐ Time-limited, individualized, measurable treatment plan	☐ Parents/Guardians participate in treatment
☐ Identifiable target behaviors that impact functioning	☐ Service providers are appropriately licensed/certified

4. The member displays impairment in the following areas (attach supporting data that demonstrates current severity level of each impairment) select all that apply:

☐ Self-injurious behavior	☐ Ability to recognize danger/risk
☐ Social/Emotional reciprocity	☐ Restrictive/Repetitive behaviors
☐ Destructive behavior	☐ Ability to advocates for self
☐ Ability to seek/develop shared social activities	☐ Expressive/Receptive language
☐ Aggressive behavior	☐ Self-Care skills impeded by symptoms of Autism

Please include the following supporting documentation with your request, where applicable ☐ Results of a standardized assessment (i.e.Vineland, ABAS, VB-MAPP) completed within the past 12 months. Re-evaluation of interventions and progress has been performed (every 6 months) to assess the need for ongoing ABA; AND a repeat validated assessment has been done every 6-12 months to demonstrate response to intervention. Include the member's IQ, if available.

- ☐ A time-limited, individualized treatment plan that has clearly defined and measured target behaviors, including baseline levels and quantifiable criteria for progress. The plan describes behavioral intervention techniques appropriate to the target behaviors, reinforcers selected, and strategies for generalization of learned skills are specified. Include baseline, interim and current data for all goals. Include the results of a functional behavior assessment and/or skills assessment, as applicable.
- ☐ Supporting data that demonstrates the level/severity of impairment justifies the number of hours requested
- ☐ Parent(s) or guardian(s) have measurable goals that work to reinforce interventions and generalize gains.
- ☐ Clearly defined, measurable, and realistic criteria for titration of hours and ultimate discharge, including an aftercare plan.
- ☐ There is involvement of, or referrals to, appropriate health care, community, or supplemental resources.
- ☐ Describe any barriers to providing this information and efforts to address those barriers.
- ☐ Any additional details to be considered for this request

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Form completed by:	Title