



ABA Prior Authorization Request Form

Provider Information			
Provider Name:			
Date Submitted:		Contracted (Y / N)	
Provider NPI:		Provider Tax ID (TIN):	
Provider Medicaid ID:		Provider Email Address:	
Provider Contact Name:		Provider Fax Number:	
Provider Phone:			
Provider Address:			
Member Information			
Member Name:		Member DOB:	
CareSource PASSE ID#:		Member Medicaid ID:	
Care Coordinator Name:			
PCSP Start Date:		PCSP End Date:	
ICD-10 Diagnosis Code:		Diagnosis Description:	
Start Date:		End Date:	

INSTRUCTIONS:

- 1.) This form should be submitted for service code(s) that require an authorization.
- 2.) Under each service category, you will find associated codes, frequency and recommended supporting documentation for submission.
- 3.) Please submit completed/signed prior authorization form and supporting documentation to the Care Coordinator’s email or Care Coordination fax: 937-396-3532.
- 4.) If you are unsure of the member’s Care Coordinator, please email CareCoordination@CareSourcePASSE.com.

By signing, I agree and acknowledge: The listed authorizations have been reviewed and are correct for the identified CareSource PASSE member. I, as a provider of services, agree the submission of this request for Prior Authorization reflects the treatment needed for the CareSource PASSE member. I understand that this form, supporting documentation, and valid PCSP are part of the review process. Failure to actively participate in any of these processes can result in delayed authorizations.

Please sign below.

Your Signature (Provider Representative)	Date:
Click to enter signature:	

Disclaimer: An authorization is not a guarantee of payment; Member must be eligible at time of services are rendered.

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Please reference the CareSource PASSE Medical Policy: [MM-1227](#) Applied Behavior Analysis for Autism

ABA Assessments	Authorization Time Period: Up to 6 months or end of PCSP		Limits/Guidelines: Auth not to exceed 8 hours (12 units combined)	
			Care Type: Elective	Frequency:
	97151 EP	Physician or BCBA	Total hrs:	Total units: (1 unit = 15 min)
	97152 EP	RBT or BCaBD	Total hrs:	Total units: (1 unit = 15 min)
	Recommended supporting Documentation		Screening/evaluation from medical professional with Autism Diagnosis; Behavioral Assessment (ie. ADOS, ADI-R)	

ABA Therapies and Supervision	Authorization Time Period: Up to 6 months or end of PCSP		Limits/Guidelines: See CareSource PASSE Medical Policy	
			Care Type: Elective	Frequency:
	97153 EP	Direct Therapy (1:1)	# of hours per wk	Total units: (1 unit = 15 min)
	97154 EP	Group Adaptive	# of hours per wk	Total units: (1 unit = 15 min)
	97155 EP	BCBA Supervision	# of hours per wk	Total units: (1 unit = 15 min)
	97155 EP	Direct Therapy (telehealth)	# of hours per wk	Total units: (1 unit = 15 min)
	97156 EP	Parent / family training	# of hours per wk	Total units: (1 unit = 15 min)
	97157 EP	Multi-family adaptive behavior	# of hours per wk	Total units: (1 unit = 15 min)
	97158 EP	Multi-family group	# of hours per wk	Total units: (1 unit = 15 min)
	Recommended supporting Documentation	<ul style="list-style-type: none"> • Behavior assessment and treatment plan performed by independent practitioner • Definitive primary diagnosis of autism made by a practitioner independent of the ABA provider • ABA order from provider • Assessment to include behavioral, psychological, developmental and medical history • IEP when ABA hours will be performed in school setting • Treatment plan to include the following: measurable SMART goals, Functional skills assessments, caregiver family training plan, # of hours per wk, • Continued Care requests: updated progress reports to show response to treatment from baseline 		

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