



Applied Behavioral Analysis (ABA) Prior Authorization Request Form

Provider facility/group name: _____

Provider taxpayer identification number (TIN): _____

Provider address: _____ Provider city, state, zip: _____

Provider phone #: _____ Provider fax number: _____

Case supervisor name and credentials: _____

Case supervisor national provider identifier (NPI): _____

Case supervisor phone number: _____ Case supervisor email: _____

Case supervisor availability for call back (please indicate days and times): _____

Member ID number: _____ Member DOB: _____

Member first name: _____ Member last name: _____

Member address: _____

Proposed authorization start date: _____ Proposed authorization end date: _____

Addendums to existing authorizations can no longer be accommodated. If you require changes to your current authorization, such as adjustments to dates of service or hours, a new prior authorization request form must be submitted for utilization review. As a result, the existing authorization will be ended.

Please ensure the prior authorization request form is completed in its entirety, rather than only including the additional hours or codes needed. The start date should be the date the change is needed, and the end date must correspond to the end date of the current authorization. Please include all codes you plan to deliver and the total hours per week/month needed for the remaining weeks (not just the additional hours or codes needed). Lastly, you must include a letter detailing the clinical rationale that supports the request for an increase in hours and/or changes in dates of service.

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HCPCS Codes

H0031 _____ **Hours** per auth period.

H0032 _____ **Hours** per Week Month

H2014 _____ **Hours** per Week Month

H2019 _____ **Hours** per Week Month

S5111 _____ **Sessions** per Week Month

CPT Codes

97151 _____ **Hours** per auth period.

97152 _____ **Hours** per auth period.

0362T _____ **Hours** per auth period.

97153 _____ **Hours** per Week Month

97154 _____ **Hours** per Week Month

97155 _____ **Hours** per Week Month

97156 _____ **Hours** per Week Month

97157 _____ **Hours** per Week Month

97158 _____ **Hours** per Week Month

0373T _____ **Hours** per Week Month

Submit the completed form to the Behavioral Health Autism Center via email at ABA@healthnet.com or fax at 855-427-4798.

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