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.

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 Health Net* Behavioral Health Autism Center via email at ABA@healthnet.com or fax at 855-427-4798.