



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

Community Health Plan of Imperial Valley ("CHPIV") is the Local Health Authority (LHA) in Imperial County, providing services to Medi-Cal enrollees in Imperial County. CHPIV contracts with Health Net Community Solutions, Inc. to arrange health care services to CHPIV patients. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.