Use for Commercial Members
Submit as attachment via Blue E Authorization Portal or Fax to 866-987-4161

Use for FEP Members Submit as attachment via Blue E Authorization Portal or Fax to 866-987-4159

Adaptive Behavioral Treatment for Autism Spectrum Disorder/Applied Behavioral Analysis (ABA/ABT)

AUTHORIZATION REQUEST

Submission of this form is only a request for services and does not guarantee approval; not all Blue Cross NC plans provide benefit coverage for autism treatment services. Incomplete forms may delay processing.

Check one: ☐ Initial Request ☐ Extension Request

1) For Initial Treatment Requests
Please Submit: Completed ABA/ABT Authorization Request Form (pages 1-5), Diagnostic Evaluation Report, Standardized Assessment (i.e., Vineland, VBMAPP), and Comprehensive Treatment Plan (additional information may be requested by a clinician once the case is reviewed)

2) For Extension Requests
Please Submit: Completed ABA/ABT Authorization Request Form (pages 1-5), Standard Re-Assessment, Comprehensive Treatment Plan (additional information may be requested by a clinician once the case is reviewed)

PATIENT INFORMATION			
Date of Request	**Patient Name**	**Patient Blue Cross NC ID Number**	**Patient Date of Birth**

PROVIDER/GROUP INFORMATION			
Servicing Provider Information		**Servicing Group Information**	
Provider Name		**Group Name**	
Provider PPN#, Tax ID # or NPI		**Group PPN#, Tax ID # or NPI**	
Street, Bldg., Suite #		**Street, Bldg., Suite #**	
City/State/Zip code		**City/State/Zip code**	
Phone #		**Phone #**	
Fax #		**Fax #**	

Please identify if claims will be under Provider or Group	☐ Provider ☐ Group

DIAGNOSTIC INFORMATION

Diagnostic Practitioner Name and Credentials			
Primary Diagnosis Code		Date of Primary Diagnosis	
Secondary Diagnosis Code (if applicable)		Date of Secondary Diagnosis	
Name of Assessment Tool for Autism Evaluation		Patient's Score	

PROVIDER TREATMENT REQUEST

Place of Service	☐ **Office** ☐ **Home** ☐ **Other:** _____ **Blue Cross North Carolina will NOT reimburse ABT services delivered in a school setting** (all types- including private and public)

ABA PROCEDURE CODE REQUEST

CPT Code	**97153**	**97154**	**97155**	**97156**	**97157**	**97158**	**0373T**
Units per 15 minutes							
Weekly (W), monthly (M), or total (T)	W / M / T	W / M / T	W / M / T	W / M / T	W / M / T	W / M / T	W / M / T

Requested Start Date		**Additional CPT Codes/Units**	

Note: Prior Review for 97151/97152 is NOT required for Commercial Plans Prior Review for 97151/97152 IS required for FEP Plans

BASELINE & ASSESSMENT INFORMATION

Please select one (1) instrument that will be utilized for the member's entire treatment episode so progress can effectively be measured. Choose a recognized instrument such as the VB MAPP, ABLLS, AFLS, ABAS or the Vineland. Also, please at ach standardized measurement scoring summaries if the member has been in treatment prior to this request.

Name of Assessment	**Current Test Date**	**Current Score**	**Previous Test Date**	**Previous Test Score**

ABA/ABT TREATMENT HISTORY			
Initial/First Date of ABA Services from current provider/facility			
Initial avg. # of hours/week		**Current avg. # of hours/week**	
Has the member had ABA services with any other provider?		☐ Yes ☒ No Initial Date: _____	

MALADAPTIVE BEHAVIORS		
Behavior	**Baseline Frequency**	**Current Frequency**
1)	_____/ per _____	_____/ per _____
2)	_____/ per _____	_____/ per _____
3)	_____/ per _____	_____/ per _____
4)	_____/ per _____	_____/ per _____
Does member require a Behavior Intervention Plan?	☐ Yes ☐ No	**Please list current strategies:**

MEMBER TREATMENT PLAN		
Member Skill Acquisition Goals	**Targeted Domains (e.g., communication, social, behavior)**	**Total # of Goals**
New Goals		
Continued Goals		
Mastered Goals		
Goals on Hold		

CAREGIVER INVOLVEMENT					
	Intro Date	**Baseline (%)**	**Measurable Caregiver Training Goals**	**Current Progress (%)**	**Expected Mastery Date**
1					
2					
3					
Total Number of Caregiver Sessions At ended:					

TREATMENT FADE/ TRANSITION/ DISCHARGE PLAN			
Individualized Discharge Objectives, Measurable Criteria, and Current Status			
Measurable Fade Plan with Criteria and Current Status			
Member's Fade Plan	Member will step down from current _____ hrs/week to _____ hrs/week, on date _____or within _____ months.		
Discharge Plan has been reviewed with caregivers:	☐ Yes ☐ No	If no, please explain:	

By signing below, I certify that I have appropriate authority to request prior authorization and certification for the item(s) indicated on this request and that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in the patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available. Finally, I certify that I've completed this form in its entirety, and I understand that an incomplete form may delay processing.

Signature:_____Date: _____

Submit this form as an at achment via the Blue E Authorization Portal with required documentation.

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