sunshine health

Fax: 1-844-208-9713

BEHAVIOR ANALYSIS PRIOR AUTHORIZATION REQUEST FORM

Please print clearly and fill out the entire form even if the information is documented in attachments. Incomplete or illegible forms will be returned.

MEMBER INFORMATION		DIAGNOSTIC & TREATMENT INFO
Member Name:		Primary Diagnosis (Required):
Medicaid ID#:		Diagnosing Clinicians Name and Credentials:
Date of Birth:	Age:	Date of Initial Diagnosis:
Phone Number:		Standardized Diagnostic Assessments Utilized:
Gender: ☐ Female ☐ Male		Co-Occurring Diagnoses:
Does the member have other insurance? ☐ Yes ☐ No (Include policy number below)		Referring Clinicians' Name and Credentials:

PROVIDER INFORMATION	
BCBA/Licensed Clinician Name and Credentials:	Group Facility Name (If applicable):
BCBA/Licensed Clinician Provider NPI:	Group Tax ID (if applicable):
Group NPI (if applicable):	Contact Name:
BCBA/Licensed Clinician direct contact Number:	Phone Number:
BCBA/Licensed Clinician email address:	Provider Address:
Fax Number:	Fax Number:
Date ABA treatment initiated:	Estimated Duration of ABA Services (planned time from initiation of care to completion, in months):
Did member transition from another insurer (proof of previous authorization required)? ☐ Yes ☐ No	

BEHAVIOR ANALYSIS SERVICES - 40 hour/week maximum (Please include the re-assessment unit request with the treatment request)
***telehealth only allowed for 97156 with limits (see fee schedule)**

Codes	Services	Dates of Services Requested	Total Units Requested	Modifier
97151	Behavioral Identification Assessment – per 15 minutes			Claims modifier only
97151	Behavioral Identification Re-Assessment – per 15 minutes			TS

Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

0362T	Assessment add-on practitioner – per 15 minutes			
97152	Behavioral Identification- Supporting Assessment – per 15 minutes			
97153	Adaptive Behavioral Treatment by Protocol – per 15 minutes			Claims modifier only
97154	Group adaptive behavior treatment with protocol modification, face-to- face with multiple patients-per 15 minutes (see fee schedule for participant amount)			Claims modifier only
97155	Behavior treatment with protocol modification- per 15 minutes			
97155	Behavior treatment with protocol modification- per 15 minutes			HN
97156	Family training by Lead Analyst – per 15 minutes			Claims modifier only
97156	Family training by assistant – per 15 minutes			HN
97158	Group adaptive behavior treatment by protocol, face to-face with two or more patients- Per 15 minutes, (see fee schedule for participant amount)			Claims modifier only
0373T	Treatment add-on practitioner			
If applicable, include rationale for 0362T and/or 0373T request below:				

Complete all fields in their entirety.

Request type:

- ☐ **Initial ABA Assessment** (Include: Comprehensive Diagnositc Evaluation (CDE), and referral for ABA)
- ☐ **Initial ABA Treatment** (Include: CDE, referral for ABA, Behavior Assessment with most recent BASC and Vineland with scoring report, Behavior Plan with requirements as indicated in 6.2.2 of the Florida Medicaid BA services coverage policy)
- ☐ **Concurrent ABA Treatment** (Include: CDE, referral for ABA, Behavior Assessment with most recent BASC and Vineland with scoring report, Behavior Plan with requirements as indicated in 6.2.2 AND 6.2.3 of the Florida Medicaid BA services coverage policy)

Treatment Setting:

Vineland-3 Comprehensive Parent Interview Form Including Maladaptive Behavior Domain (for all recipients)

Date of most recent assessment: _____
Score of most recent assessment: _____
Score of previous assessment: _____

Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), (for all recipients 2 years old and less than 19 years old)

Date of most recent assessment: _____
Score of most recent assessment: _____
Score of previous assessment: _____

Any other Assessments used:

Assessment name: _____

Date of most recent assessment: _____

Score of most recent assessment: _____

Score of previous assessment: _____

Discharge plan (Anticipated date to transition to a lower level of care):

Describe how treatment is being coordinated with other providers involved in Member's Care (i.e. PCP, Psychiatrist, OT, PT, ST, Behavioral health Therapist, School, other services):

Provider information on current functional impairment in the following areas (please indicate if no functional impairment is present):

Safety:

Communication:

Self-stimulating:

Self-care:

Other behaviors not identified above but not limited to complexity of treatment, programming, or environmental variables:

Schedule of requested BA services:

BCBA/Licensed Clinician Signature: _____ **Date**: _____

By signing the above, I attest that all individuals rendering service under the proposed treatment plan have the appropriate training and education required to render services.