Florida community care

P.O. Box 261060 / Miami, FL 33126

# ABA Request for Prior Authorization Form

FAX to 305-675-6138 • Email: fccumdepartment@fcchealthplan.com

☐ Standard ☐ Expedited* (By checking this option, I certify that applying the standard time frame may serious\ jeopardize the life of health of the patient or the patient's ability to regain maximum function.)

Date of Request: / /

If you are requesting services for a member aged **21 years or older**, please complete **Sections A, B, D, F, H, and I**. For members **under 21 years** of age, complete **Sections A, B, C, E, G and I.**

## SECTION A MEMBER INFORMATION

Name: Medicaid ID Number:

Date of Birth: / / Gender (circle one): M F Primary Diagnosis (ICD-10 Code):

Other insurance:

## SECTION B ABA PROVIDER INFORMATION

Agency Name: Contact:

Email:

Address: City: State: Zip:

Phone: Fax: NPI #: TIN #:

## SECTION C REFERRING PHYSICIAN OR PROVIDER INFORMATION

Physician/Provider Name: Specialty:

Signature of Requesting Physician:

Contact: Email:

Address: City: State: Zip:

Phone: Fax: NPI #: TIN #:

## SECTION D AUTHORIZATION INFORMATION

Requested Start Date: / / Requested End Date: / /

☐ H2019UCHP BCBA Level 1 _____ requested 1/4 hrs* ☐ **BSP creation**

☐ H2019UCHO BCBA Level 2 _____ requested 1/4 hrs* ☐ **Continued Service**

☐ H2019UCHN BCaBA _____ requested 1/4 hrs*

☐ H2019UCHM Behavior Assistant_____ requested 1/4 hrs*

*1/4 hour = 1 unit/15-minute interval*

## SECTION E REFERRAL/AUTHORIZATION INFORMATION

Requested Start Date: / / Requested End Date: / /

Diagnosis CPT/HCPC Code & description:

Date of Service: / / Units Requested:

**Type of Procedure (Circle one):** ☐ Inpatient ☐ Outpatient ☐ In Office

Other Clinical Information (Include clinical notes, labs, radiology reports, etc.): _____

_____

_____

_____

If this is a request for reauthorization of a previously approved request, please provide recent clinical documentation. Please Note: Failure to include correct procedure codes or diagnosis codes may result in a delay in processing the service authorization request.

**REASON FOR REFERRAL:**

Identify the severe challenging behaviors that present a health or safety risk to self or others or

☐ Health Risk ☐ Self-Injury ☐ Aggression toward other ☐ Destruction of property

☐ Stereotyped/Repetitive Behaviors ☐ Elopement ☐ Severe disruptive Behavior

## SECTION F REQUIRED DOCUMENTATION

☐ BSP Creation – attach completed Functional Behavior Assessment (FBA). Approval will be for 90- days to complete Behavior Support Plan (BSP).

☐ Continued Services – attach most recent approved Behavior Support Plan (BSP) and data summary with progress. Include most recent LRC information (submitted, reviewed, approved, etc)

## SECTION G REFERRAL/AUTHORIZATION INFORMATION

**ASSESSMENT TOOL USED FOR DIAGNOSIS AND FINDINGS:**

**CURRENT DIAGNOSIS:**

**SPECIFY ASD DIAGNOSIS ESTABLISHED AND BY WHOM**

(Note: attaching documentation is mandatory)

- Documentation must be within the last 24 months by a MD, PhD in Psychology or PsyD.
- Diagnosis must meet DSM-5 criterion to diagnose ASD.
- Validated assessment tools must be included.

**COMPREHENSIVE DIAGNOSTIC EVALUATION COMPLETED?** ☐ **YES** ☐ **NO**

**OT EVALUATION?** ☐ **YES** ☐ **NO**

**SPEECH AND LANGUAGE EVALUATION COMPLETED** ☐ **YES** ☐ **NO**

**OTHER EVALUATION & DIAGNOSIS TESTS TO RULE OUT OTHER CONDITIONS COMPLETED?** ☐ **YES** ☐ **NO**

## SECTION H ADDITIONAL REQUIREMENTS

ABA providers are required to submit BSPs to their respective Local Review Committee (LRC) within 5-days of development. These plans should be submitted to the following email addresses:

| | |
|---|---|
| Central Region | central.behavioral@apdcares.org |
| Suncoast Region | suncoast.behavioral@apdcares.org |
| Southern Region | southern.behavioral@apdcares.org |
| Northwest Region | northwest.behavioral@apdcares.org |
| Northeast Region | northeast.behavioral@apdcares.org |
| Southeast Region | southern.behavioral@apdcares.org |

Please use ICMC Program LRC (members initials) in subject line of email and cc the Care Coordinator at FCC.

## SECTION I ATTESTATION

I attest that the information above is accurate and complete, and that the requested services are necessary.

Provider/Rep. Signature Date: / /

Provider/Rep. Name: Title: