Florida community care

Florida Community Care LLC
P.O. Box 261060
Miami, Florida 33126

Florida Community Care

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 72 hrs. review time frame may seriously jeopardize the life of health of the patient or the patient's ability to regain maximum function.)

Please complete **all sections** legibly.

Date of Request: ______________________

MEMBER INFORMATION

Name: ____________________________ ID Number: __________________________

Date of Birth: ____/____/________ PCP Name: __________________________

Other Insurance: _________________________ Gender (circle one): M F

REFERRING PHYSICIAN OR PROVIDER INFORMATION

Referring Provider/Requesting Provider

Name: ______________________________

Address: ____________________________

____

Phone: ______________________________

Fax: _________________________________

Contact Person: ______________________

Performing Provider/Facility

Performing Provider/Facility

Name: ______________________________

Address: ____________________________

____

NPI #: ______________________________

TIN # ______________________________

Phone: ______________________________

Fax: ________________________________

Specialty: ____________________________

Signature of Requesting Physician: ____

REFERRAL/AUTHORIZATION INFORMATION

Diagnosis Code & Description: ____

CPT/HCPCS Code & Description: ____

Date of Service: ____/____/________ Number of Visits/ Units Requested: ______________

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

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

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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 significantly interfere with home or community activities.

☐ Health Risk
☐ Self-Injury
☐ Aggression toward others
☐ Destruction of property
☐ Stereotyped/Repetitive Behaviors
☐ Elopement
☐ Severe disruptive Behavior

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.

DEVELOPMENTAL 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? ____

____

LIST MEDICATIONS (Include frequency and dosage):
Is the member medication adherent? ____________________________________

____

____

MEDICAL ISSUES:

Other Physical Factors: ____

Date and results of last physical exam: ______________________________________

Date and results of last dental exam: ____

Date and results of last hearing exam: _______________________________________

Date and results of last vision exam: ____

SPECIAL SUPPORT SERVICES (Provided by the school district, regional center of early childhood program): Please describe. If there is a current IEP, please include copy.

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